

15037

CERTIFICATE OF DEATH

15840

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY in 1b 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 518 Oxford Street	
3. NAME OF DECEASED (Type or print) 3-#33337 Robert S. Adams		4. DATE OF DEATH Month 11 Day 4 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEP DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1906
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 30 Days 4 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Peter Adam		14. MOTHER'S MAIDEN NAME Essie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 248-09-2041	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 11/4 , 19 66 that (I) (we) last saw the deceased alive on 11/4 , 19 66 , and that death occurred at ----- M, from causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman M.D.		22b. DATE SIGNED 11/4/66	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-14-66	23b. DATE THEREOF 11-14-66	23c. NAME OF CEMETERY OR CREMATORY U. S. Nat. Chrl. Schol	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR William B. Case II		25. REC'D BY REGISTRAR 108 W. Washington St.	
25. REC'D BY REGISTRAR NOV 15 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYIA

12037

[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Includes various lines of text, some numbers, and a circular stamp on the right side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 3 Per telephone call from funeral director

15038

CERTIFICATE OF DEATH

12/1/66 mh

15041

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 12 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-5, Box-27-A	
3. NAME OF DECEASED (Type or print) First Oslar Middle Oslar Last Gordon ALLEN		4. DATE OF DEATH Month November Day 15 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1918
9. AGE (In years last birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Utility	
11. BIRTHPLACE (County & State, or foreign country) A.A.Co Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Acton Allen		14. MOTHER'S MAIDEN NAME Goldie M. Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 214-05-0860	
17. INFORMANT Lucille C. Allen		Address Annapolis, Md Rt 5 Box 27A	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Art. C.V. disease & hypertension DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from 11/4/66 , 19 66 , to 11/15 , 19 66 that (I) (we) last saw the deceased alive on 11/14/66 , 19 66 , and that death occurred at 5:30 AM from causes and on the date stated above.			
22a. SIGNATURE Maurice F. Klawans		22b. DATE SIGNED 11-16-66	
22c. PHYSICIAN'S NAME (Type) MAURICE F. KLAWAYS		22d. ADDRESS 31 SOUTH GATE AV. Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/18/66	
23c. NAME OF CEMETERY OR CREMATORY Asbury Broadneck Church A.A.Co		23d. LOCATION (City or Town) (County) (State) Md	
24. FUNERAL DIRECTOR C.E. Hicks, 111		25a. REC'D BY REGISTRAR NOV 23 1966	
ADDRESS Annapolis, Maryland		25b. REGISTRAR'S SIGNATURE J. J. Judge	

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

15001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15039

CERTIFICATE OF DEATH

15042

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>Md.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Earleigh Heights Rd.</i>		d. STREET ADDRESS <i>Earleigh Heights Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Nicholas</i> Last <i>Allender, Jr.</i>		4. DATE OF DEATH Month <i>11</i> Day <i>2</i> Year <i>1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-29-1892</i>
9. AGE (in years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>14</i>	IF UNDER 24 HRS. Hours <i>14</i> Min. <i>00</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Mechanic</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Balto. City Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Nicholas William A. Allender, Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Clara A. Holland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212128135</i>	
17. INFORMANT <i>Mr. Howard C. Allender</i>		Address <i>1658 Myamby Rd. #4</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>coronary occlusion</i> (a), stating the underlying cause last. DUE TO (c) <i>arteriosclerotic Cardiovascular disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>few hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1966</i> to <i>1966</i> , that (I) (we) last saw the deceased alive on <i>11/5/66</i> , and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>R M Smith</i>		22b. DATE SIGNED <i>Nov. 3, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>RAY M. Smith M.D.</i>		22d. ADDRESS <i>Severna Park Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE THEREOF <i>11/5/66.</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc. Baltimore, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 7 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

15025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15040						15043					
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>					
c. LENGTH OF STAY IN 1b <u>20 years</u>						d. STREET ADDRESS <u>Box 659, Rt 2</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>127 Box 659</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura Dorothy Armstrong</u>						4. DATE OF DEATH Month Day Year <u>11-14-66</u> <u>19</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>24 Jan 1885</u>		9. AGE (in years last birthday) <u>81 yrs.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Rehahn</u>						14. MOTHER'S MAIDEN NAME <u>L. Spengler</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>130 301347</u>		17. INFORMANT Address <u>127 Box 659</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>											
4221 DUE TO (b) <u>A.C.V.D.</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Gen. Card</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19....., to <u>1966</u> , 19....., that (I) (we) last saw the deceased alive on <u>11-14-66</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>						22d. ADDRESS <u>P.O. Box 73 Severna Park</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>11/15/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Local Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Greene Co., N.Y.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barranco</u>						ADDRESS <u>Severna Park, Md</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ROBERT S. BARRANCO											

MEDICAL CERTIFICATION

12000

12000

STATE OF TEXAS

12000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15041

CERTIFICATE OF DEATH

15044

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL: Shady Side 02-1	
d. STREET ADDRESS Avalon Shores		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Frank Last BEINLICH		4. DATE OF DEATH Month November Day 22 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1895
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U. S. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY Printing Office	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WWI 6-21-1916 8-31-1921		16. SOCIAL SECURITY NO. 6-21-1916 8-31-1921	
17. INFORMANT Mildred E. Beinlich		Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation + cardiac arrest 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) Arteriosclerotic heart disease - coronary insufficiency		INTERVAL BETWEEN ONSET AND DEATH 3 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan , 19 61 , to Nov. 22 , 19 66 , that (I) (we) last saw the deceased alive on Nov. 22 , 19 66 , and that death occurred at 9:00 AM M, from causes and on the date stated above.		22a. SIGNATURE Willard F. Smith M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED 11/22/66	
22c. PHYSICIAN'S NAME (Type) Willard F. Smith, M.D.		22d. ADDRESS Shady Side, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 25-1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Simmons Bros.		25a. REC'D BY REGISTRAR NOV 23 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 1661-Good Hope Rd SE Wash DC	

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

15051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15042

CERTIFICATE OF DEATH

15045

1. PLACE OF DEATH a. COUNTY <u>AA</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falesville</u> c. LENGTH OF STAY IN TB <u>70 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falesville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Christian Benning</u> First Middle Last 4. DATE OF DEATH <u>Nov 8 1966</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>11-15-88</u> 9. AGE (in years last birthday) <u>77</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Dept</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Shedyside Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carl Benning</u> 14. MOTHER'S MAIDEN NAME <u>Fredricka Witt</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO <u>213365454</u> 17. INFORMANT <u>Elmer Benning</u> Address <u>Falesville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Arteriosclerotic heart disease & coronary insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease & coronary insufficiency</u> (c) <u>coronary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute congestive heart failure & diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> years 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Jan</u> 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> to <u>Nov. 8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov. 7</u> , 19 <u>66</u> , and that death occurred at <u>3 AM</u> , from causes and on the date stated above. 22a. SIGNATURE <u>Willard F. Smith</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith MD</u> 22d. ADDRESS <u>Shady Side, Md.</u> 22b. DATE SIGNED <u>11/8/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11-11-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>2nd Aker</u> 23d. LOCATION (City or Town) (County) (State) <u>Falesville AA MD</u>		24. FUNERAL DIRECTOR <u>Bernard Hartsely</u> ADDRESS <u>Falesville Md</u> 25a. REC'D BY REGISTRAR <u>NOV 22 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15043

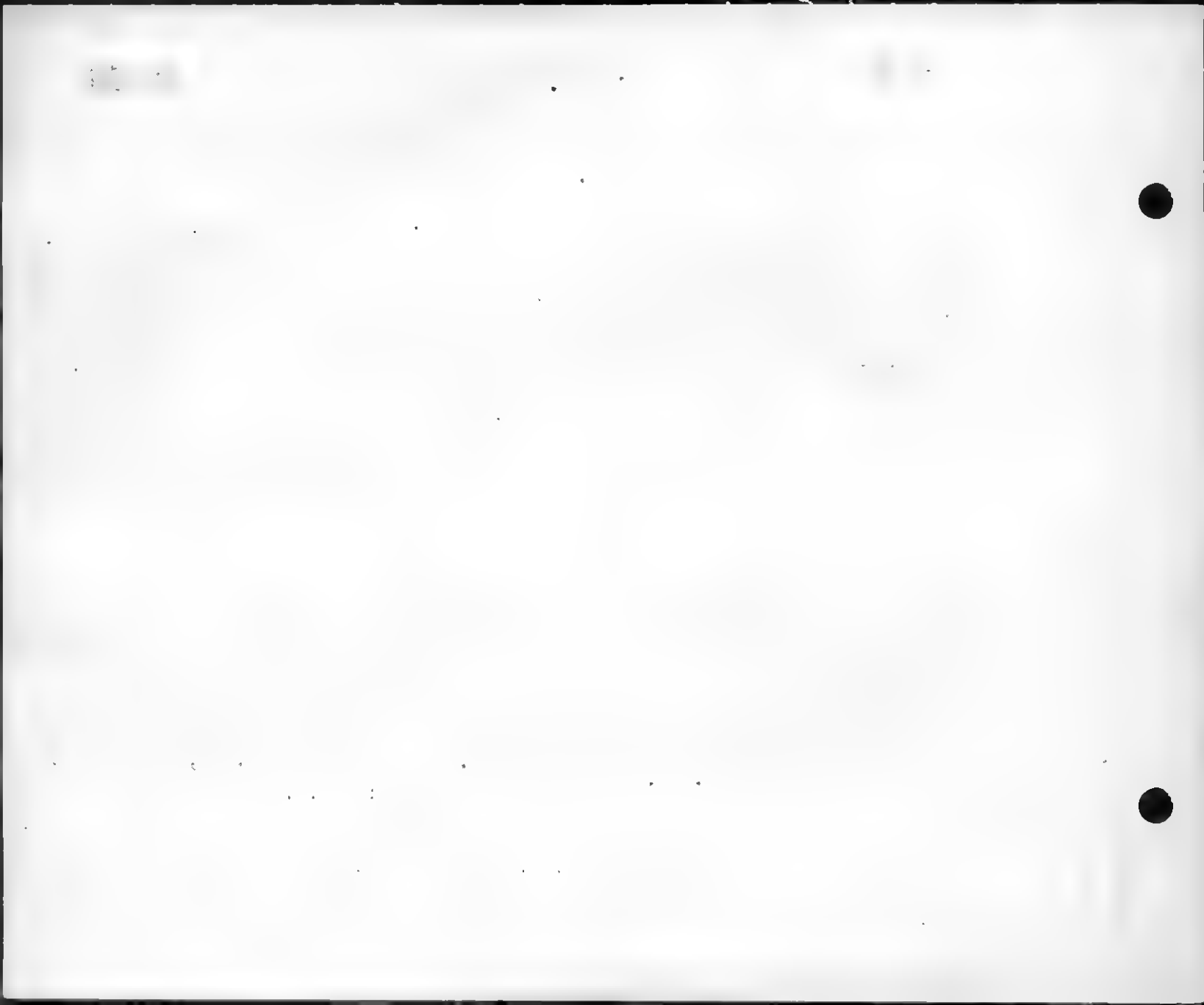
CERTIFICATE OF DEATH

15046

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 1 hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 70 W. Washington St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ERIC Middle				4. DATE OF DEATH Month November Day 11 Year 19 66			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH November 11, 1966		9. AGE (in years last birthday) yrs. 1 Min 10	IF UNDER 1 YEAR Months 1 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph Semebly				14. MOTHER'S MAIDEN NAME Bonnie Ray Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Barbara Johnson Address Anna, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURITY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 7:10 P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (husband) attended the deceased from Nov. 11, 1966 to Nov. 11, 1966 that (I) (we) last saw the deceased alive on Nov. 11, 1966 , and that death occurred at 7:10 P.M. from causes and on the date stated above.							
22a. SIGNATURE Charles B. Hargrove M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED November 12, 1966	
22c. PHYSICIAN'S NAME (Type) Charles B. Hargrove M. D.				22d. ADDRESS Hahn Prof. Bldg., Severna Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11-15-66		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City or Town) (County) (State) Annapolis Md	
24. FUNERAL DIRECTOR William Reese Anna, Md.				25a. REC'D BY REGISTRAR NOV 15 1966		25b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15044

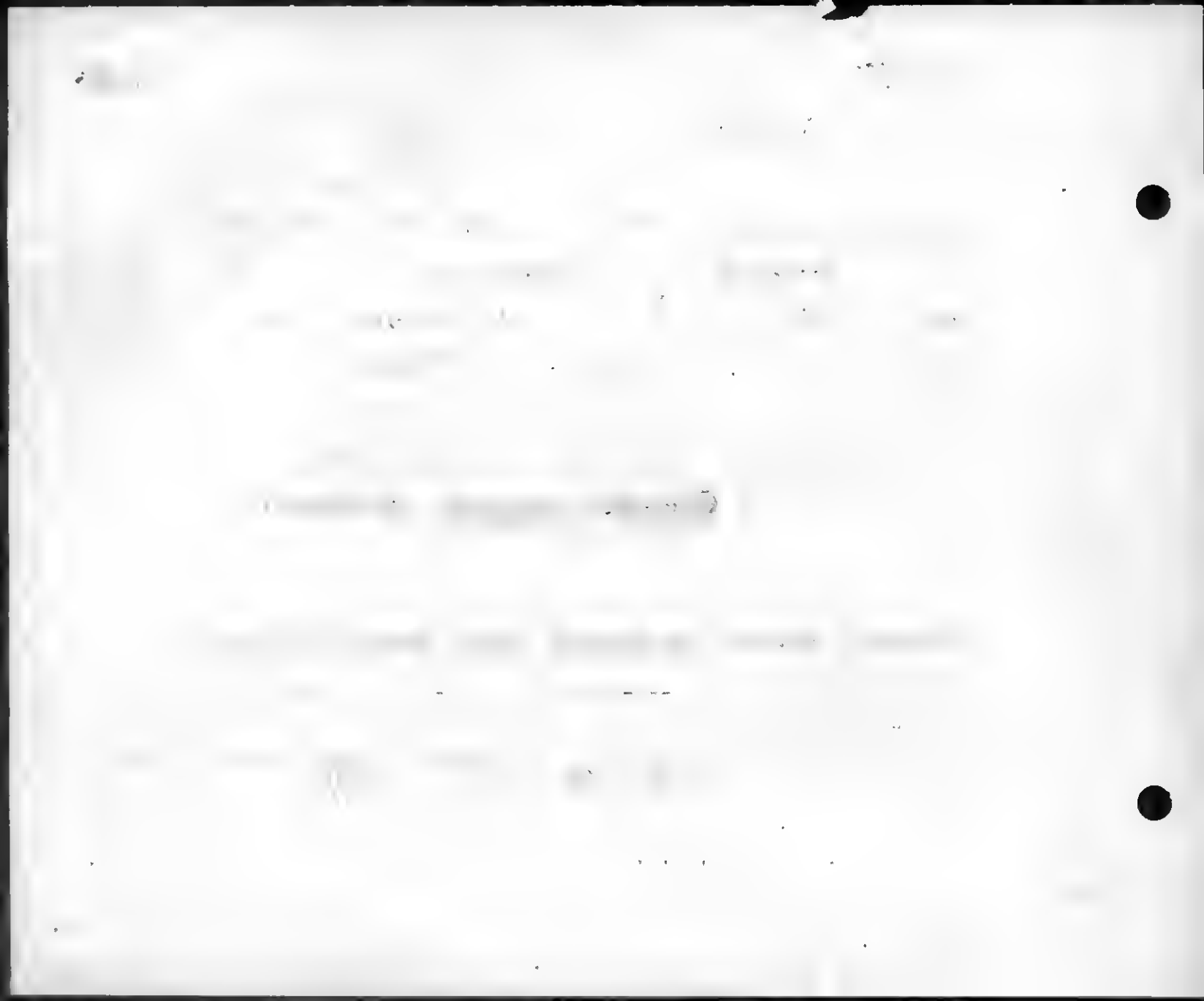
CERTIFICATE OF DEATH

15047

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL CROWNSVILLE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY in lb 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville STATE HOSPITAL		d. STREET ADDRESS BOX 42, RIVA Rd.	
3. NAME OF DECEASED (Type or print) First FRANK Middle BERWINKEL Last 4. DATE OF DEATH Month 11 Day 13 Year 1966		8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-11-1886
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinetmaker (ret.)		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) HUNGARY		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-54-9796	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PEREPRO-VASCULAR ACCIDENT DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME SEC ARTERIOSCLEROSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year ----- p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-11-1966 to 11-13, 1966 that (I) (we) last saw the deceased alive on 11-13, 1966 and that death occurred at 1055 PM , from causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 11/14/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/17/66	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Switland Md.
25a. REC'D BY REGISTRAR Beverly E. Hopping Hopping Funeral Home		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Each page please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

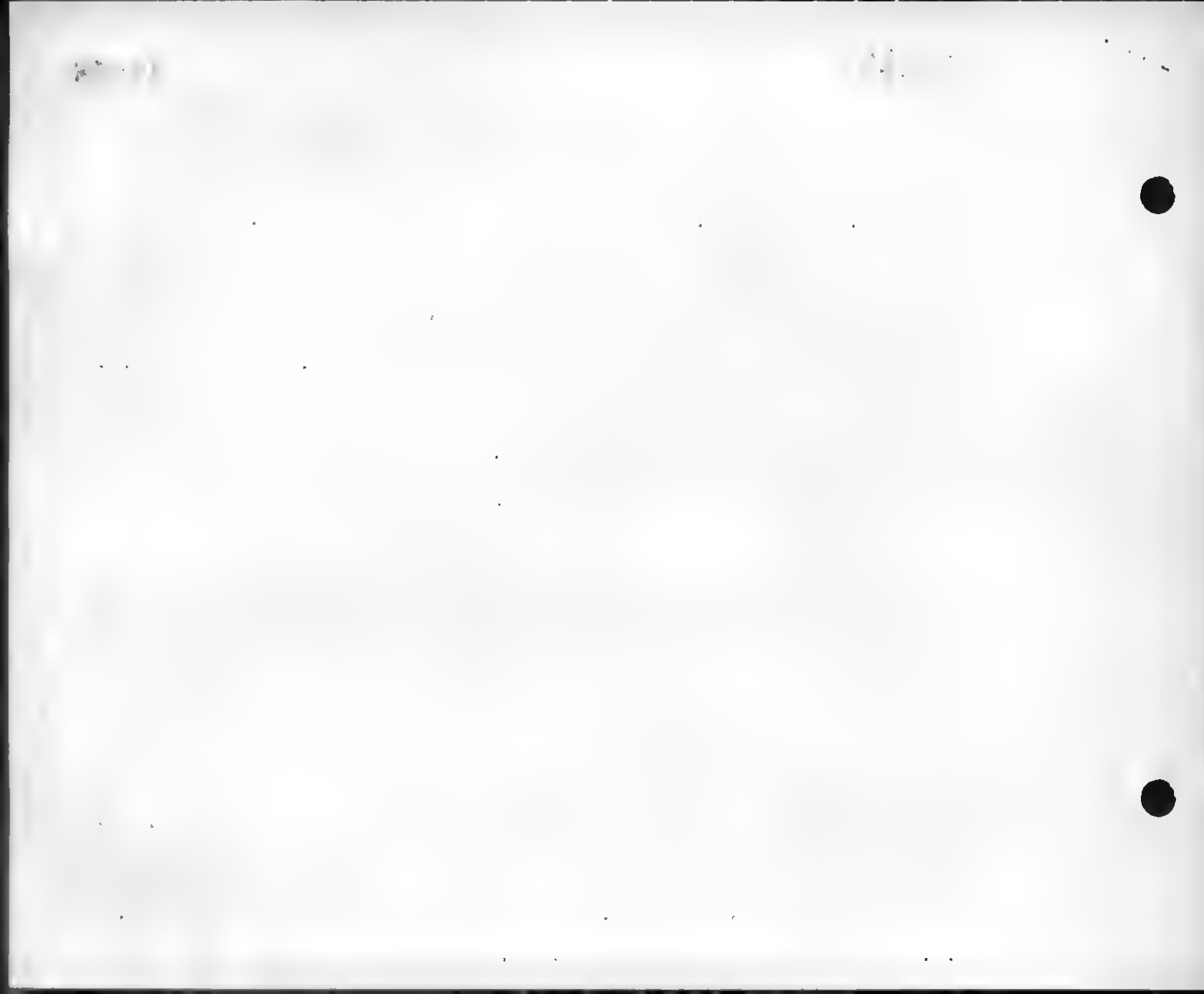
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15045

CERTIFICATE OF DEATH

15045

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN 1b 10 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6502 A N. CHARTER RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MIDDLE Last ETHEL BOUNO		4. DATE OF DEATH Month Day Year NOVEMBER 22 19 66	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JULY 7, 1881
9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE (RET)	
11. BIRTHPLACE (County & State or foreign country) SCRANTON, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BARNUM (OCSSO)		14. MOTHER'S MAIDEN NAME ELEANOR RANDOLPH (OCSSO)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MRS. BETTY RETHILL		Address SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1966 <i>Psychogenic sarcoma</i> DUE TO (b) <i>Paraneoplastic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH 8 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 29, 1966, to Nov 22, 1966; that (I) (we) last saw the deceased alive on Nov 22, 1966, and that death occurred at 9:59 AM, from causes and on the date stated above.			
22a. SIGNATURE Robert Oabolins		22b. DATE SIGNED NOV. 22, 1966	
22c. PHYSICIAN'S NAME (Type) ROBERT OABOLINS MO		22d. ADDRESS 400 CRAIN HIGHWAY NW GLEN BURNIE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV 25, 1966	23c. NAME OF CEMETERY OR CREMATORY MT. GREENWOOD CEMETERY	23d. LOCATION (City or Town) (County) (State) TRUCKSVILLE, PA.
24. FUNERAL DIRECTOR R.V. SINGLETON		25a. REC'D BY REGISTRAR GLEN BURNIE, MO. DATE NOV 23 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

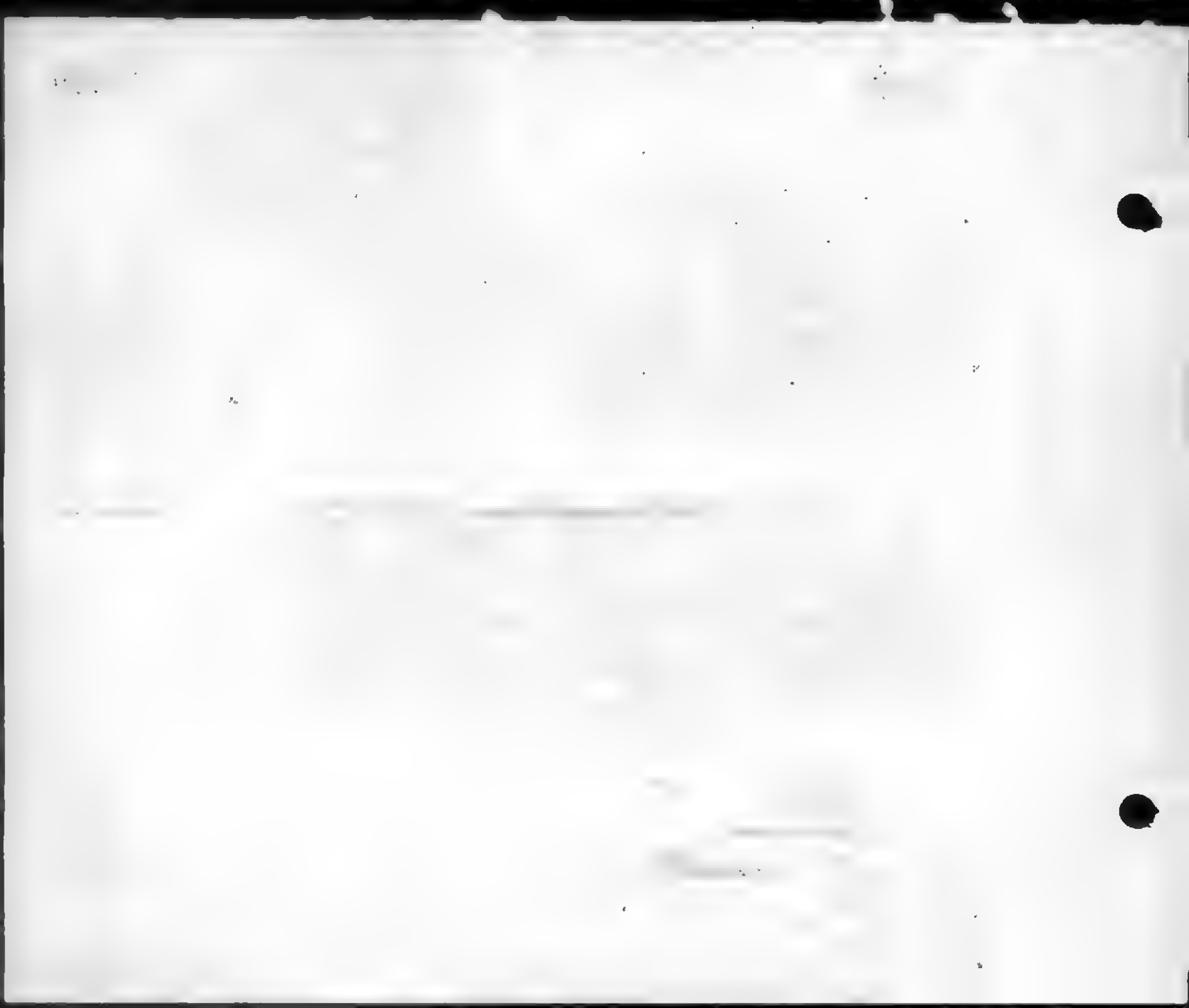
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15046

15049

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A.A. GENERAL Hospt</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SHOREACRES</u> d. STREET ADDRESS <u>ARCHD, MD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>CHARLES F. BRADFORD SR.</u>		4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1966</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>9</u> Day <u>4</u> Year <u>1876</u>		9. AGE (in years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dairy Products</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>				11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>William Bradford</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Cornis</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT Address <u>CHARLES F. BRADFORD JR. #2</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis generalized</u> 4500 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____																INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>E. L. Whitworth</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <u>11/2/66</u>							
EXAMINER'S NAME (Type) <u>E. L. Whitworth</u>				Address (Street, city, town, or county) _____				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>10-5-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>GLENN HAVEN</u>				23d. LOCATION (City, town or county) <u>GLENN BURKE MD.</u> (State) _____			
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons</u>				ADDRESS <u>Annapolis, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>NOV 4 1966</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15103

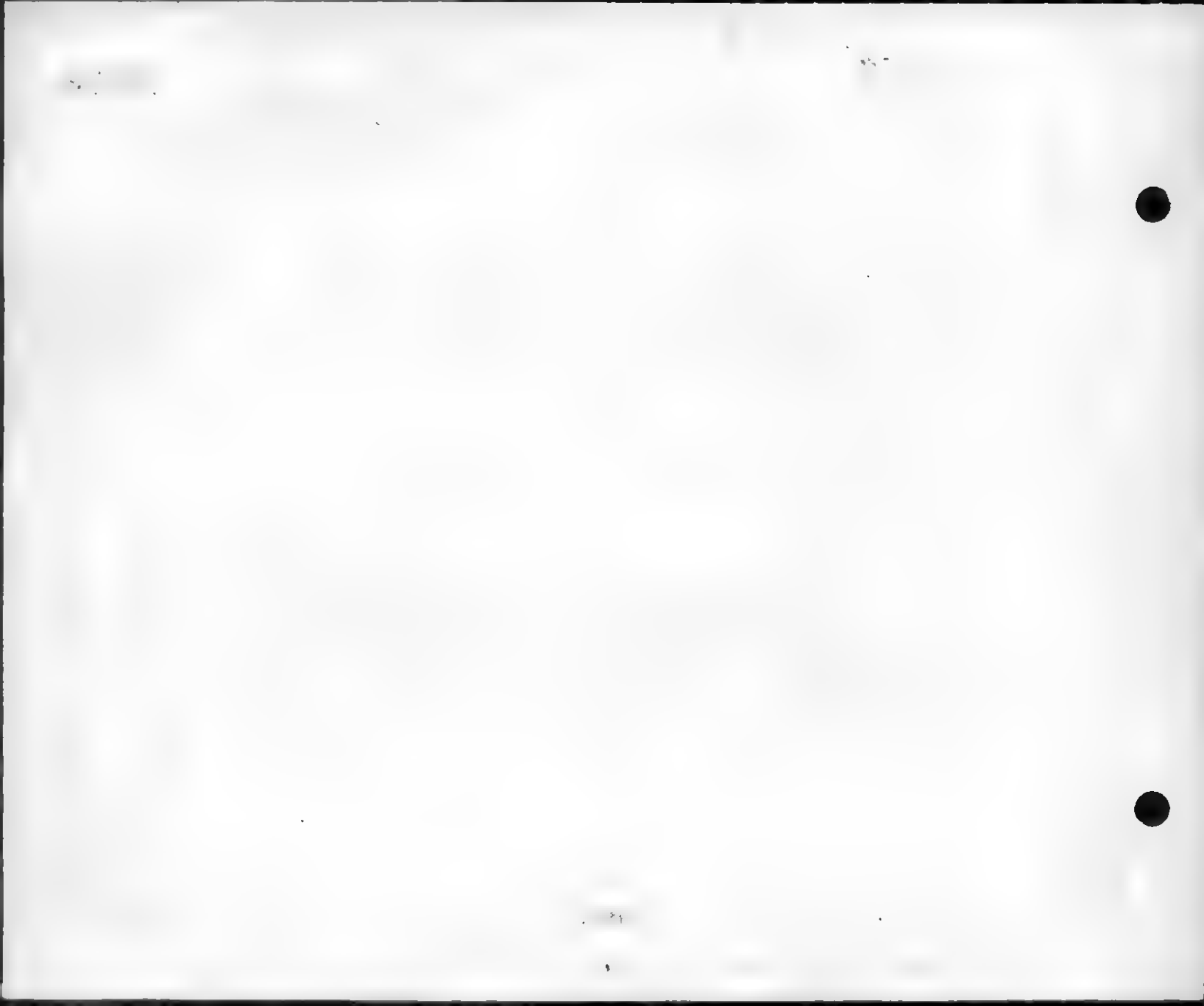
CERTIFICATE OF DEATH

15103

1 PLACE OF DEATH Anne Arundel a. COUNTY Crownville State Hosp MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ann 92045		c. LENGTH OF STAY in lb	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AnnAPolis		d. STREET ADDRESS 20, Shaw St. Annapolis	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Beent, mick First Middle Last		4. DATE OF DEATH 2.9.66 Month Day Year 11 5 19 66	
5 SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2.22.13
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) unknown		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown to us		14. MOTHER'S MAIDEN NAME unknown to us	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Hospital record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Alcoholism in late stage DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 11/3/66 , 19 to 11/5/66 , 19, that (1) (we) last saw the deceased alive on 11/5/66 , 19, and that death occurred at 2:15 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Benedict M D.		22b. DATE SIGNED 11/5/66	
22c. PHYSICIAN'S NAME (Type) BENEDICT M D.		22d. ADDRESS Crownville State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-9-66	23c. NAME OF CEMETERY OR CREMATORY Chews Memorial	23d. LOCATION (City or Town) (County) (State) Owensville Md
24. FUNERAL DIRECTOR William Reese II		ADDRESS Anna: Md.	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE NOV 14 1966			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~They~~ Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15047

CERTIFICATE OF DEATH

15050

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Anundel General Hospital				d. STREET ADDRESS 530 Harbor Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Aubrey Stanton BROWN				4. DATE OF DEATH Month Day Year November 25 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1894 December 8, 1894	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET.		10b. KIND OF BUSINESS OR INDUSTRY SALESMAN		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME J. THOMAS BROWN				14. MOTHER'S MAIDEN NAME HONORA EATON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT ANNA MAYRETTA BROWN #2 Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Myocardial Infarction 7201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from Nov 22, 1966 , to Nov. 25, 1966 , that (I) (physician) last saw the deceased alive on Nov 25, 1966 , and that death occurred at 10:48 pm , from causes and on the date stated above.							
22a. SIGNATURE Monny R. Williams M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/27/66	
22c. PHYSICIAN'S NAME (Type) M. F. KLANA				22d. ADDRESS 31 S. ...			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 11-29-66		23c. NAME OF CEMETERY OR CREMATORY Old St. Pauls Church		23d. LOCATION (City or Town) (County) (State) CHESTERTOWN KENT MD.	
24. FUNERAL DIRECTOR John M. ...				25a. REC'D BY REGISTRAR DATE NOV 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15048

15051

1. PLACE OF DEATH a. COUNTY <u>AA Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>EDGEWATER (RURAL ANNAPOLIS)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tal, give street address) <u>ANNE ARUNDEL GEN. HOSP.</u>		e. STREET ADDRESS <u>RT #1 Box 370</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES CLINTON BROWN</u>		4. DATE OF DEATH <u>Nov 5 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 7 1893</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. INSURANCE AGT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SANDVILLE W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES L. BROWN</u>		14. MOTHER'S MAIDEN NAME <u>CORA VIRGINIA BOSWORTH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>CHELLA PEARL BROWN #2</u>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 m 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1 1966</u> to <u>Nov 5 1966</u> that (I) (we) last saw the deceased alive on <u>Nov 5 1966</u> and that death occurred at <u>7:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>General Blumh</u>		22b. DATE SIGNED <u>11/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gorman E. HUNTER</u>		22d. ADDRESS <u>121 CASTLEMAN ST ANNAPOLIS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-8-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAYO MEM. CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>MAYO AA Co MD</u>
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR - SONS ANNAPOLIS MD</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 10 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15049

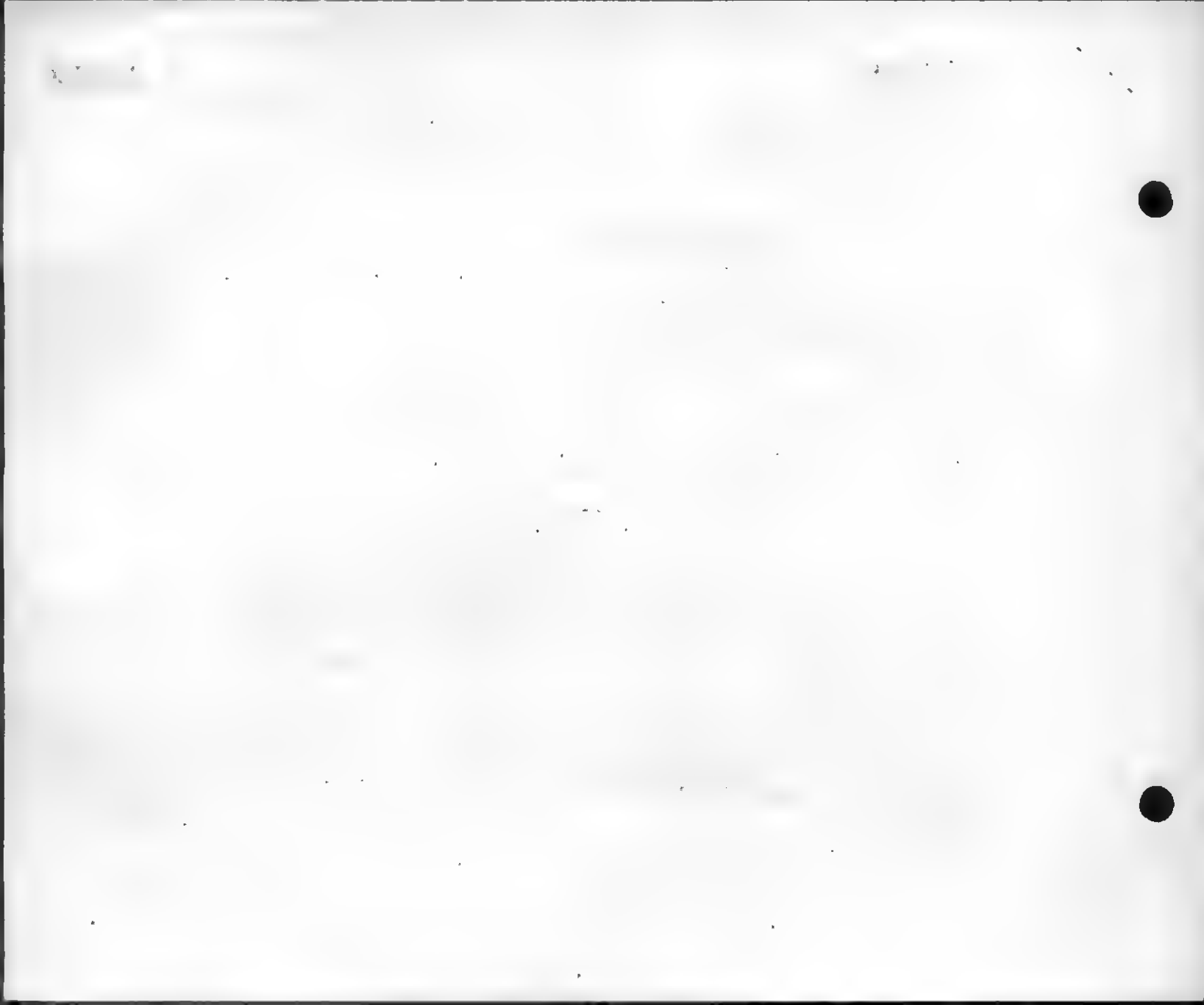
CERTIFICATE OF DEATH

15052

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ODENTON	
c. LENGTH OF STAY in 1b 1 day		d. STREET ADDRESS 461 Oakton Ave	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle R Last BURK, Sr.		4. DATE OF DEATH Month NOVEMBER Day 28 Year 19 66	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 JUN 1905
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Army) Ret.		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISSAC JOSH BURK		14. MOTHER'S MAIDEN NAME DENICE FALIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO 216-18-6593	
17. INFORMANT Hazel M. Burk		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolization right atrium acute myocardial infarction (massive) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 27 Nov , 19 66 , to 28 Nov , 19 66 , that (I) (we) last saw the deceased alive on 8:00PM 28 Nov 1966 , and that death occurred on 8:20PM , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 28 Nov 66	
22c. PHYSICIAN'S NAME (Type) BENZON BENATAR, CAPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 2/1966	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park, Glen Burnie, Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND		25a. REC'D BY REGISTRAR NOV 30 1966	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15050

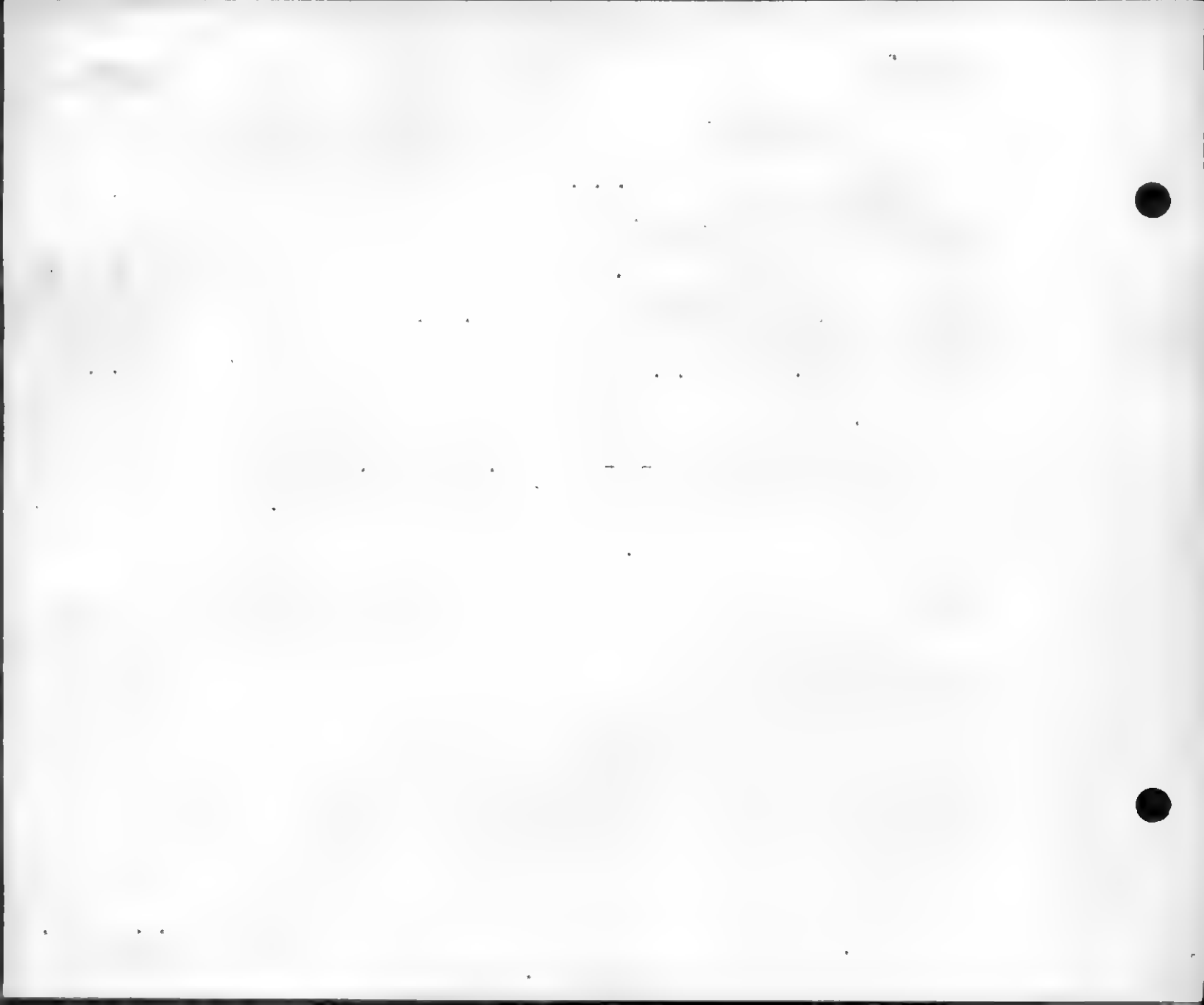
CERTIFICATE OF DEATH

15053

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN Ib D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital			d. STREET ADDRESS XXXX Sylvan Shores		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle G. Last BURKE			4. DATE OF DEATH Month November Day 15 Year 19 66		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1903	9. AGE (in years lost birthday) yrs 63	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cartography Eng. (ret)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (County & State, or foreign country) Pittston, Pennsylvania	
13. FATHER'S NAME Edward J. Burke			14. MOTHER'S MAIDEN NAME Catherine Costello		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 579-16-2930		17. INFORMANT Mrs. Dorothea S. Burke - same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident SSIX DUE TO (b) Essential Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (c) Unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/18 , 19 63 , to 10/20 , 19 66 , that (I) (we) last saw the deceased alive on 10/20 , 19 66 , and that death occurred at 12:50 P.M. , from causes and on the date stated above.					
22a. SIGNATURE Richard I. Hochman, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/15-66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/18/66	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.		
24. FUNERAL DIRECTOR Everley E. Hopping Hopping Funeral Home		ADDRESS Burial & Hopping Annapolis, Md.		25. REC'D BY REGISTRAR NOV 21 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

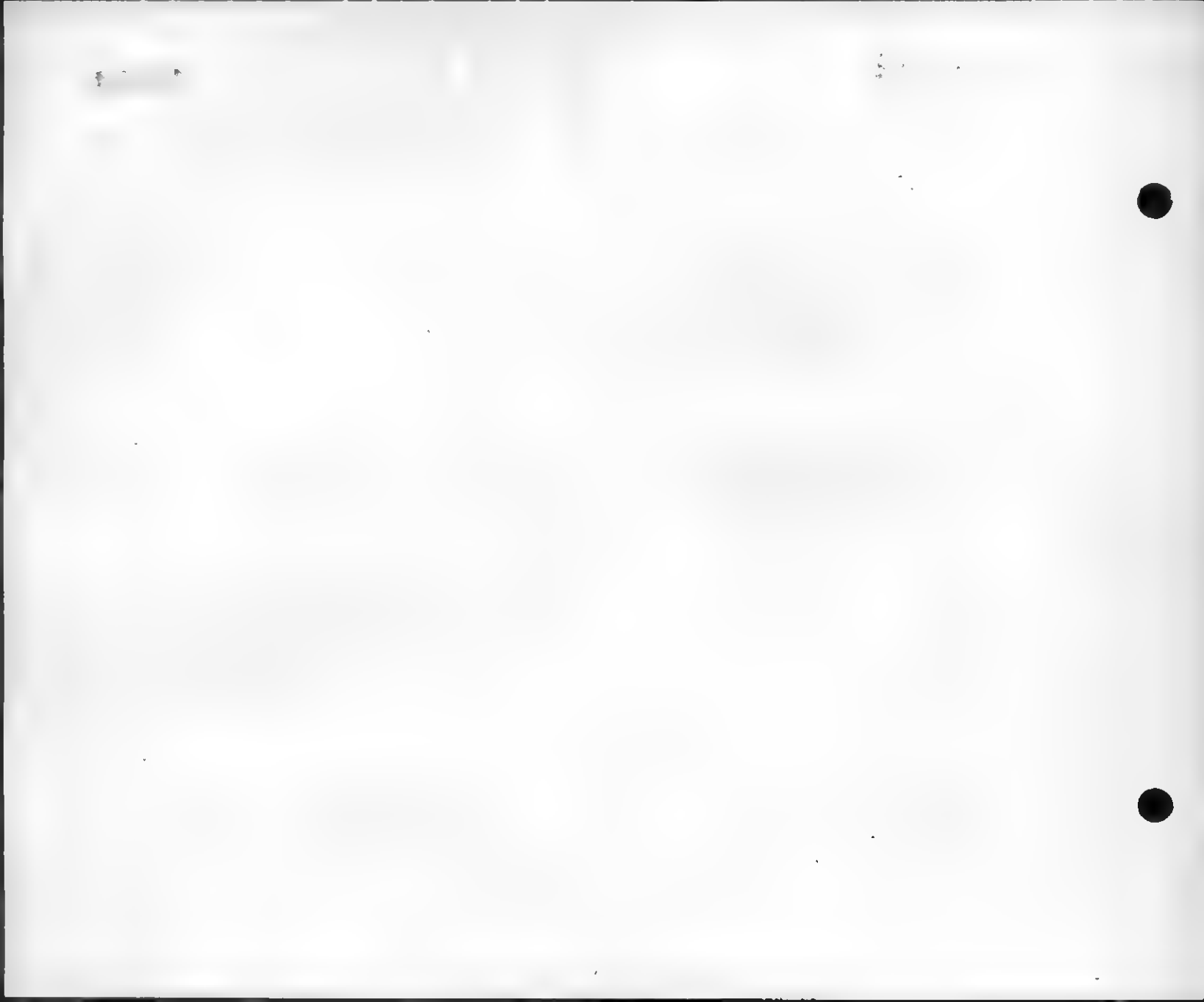
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15051

CERTIFICATE OF DEATH

15054

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY in 1b 2 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL				d. STREET ADDRESS 2 VIRGINIA AVE			
3. NAME OF DECEASED (Type or print) First GEORGE Middle BUTLER Last BUTLER				4. DATE OF DEATH Month NOVEMBER Day 24 Year 1966			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 1, 1892		9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months 74 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10b. KIND OF BUSINESS OR INDUSTRY CHURCH		11. BIRTHPLACE (County & State or foreign country) NEW FOUNDLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME EDWARD BUTLER				14. MOTHER'S MAIDEN NAME SUSAN LITTLEJOHN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. BEULAH B. BUTLER (Aunt) Address #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive heart failure DUE TO (b) Myocardial Infarction DUE TO (c) Coronary - heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 11-24, 1966 , to 11-24, 1966 , that (1) (we) last saw the deceased alive on 11-24, 1966 , and that death occurred at 4:40 AM , from causes and on the date stated above.							
22a. SIGNATURE Ernest A. Leipold M.D.				22b. DATE SIGNED 11-24-66		22c. PHYSICIAN'S NAME (Type) ERNEST A. LEIPOLD	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 28, 1966		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pa. Geo. Co. Md.	
24. FUNERAL DIRECTOR Arthur Waters Washington, D.C.				25a. REC'D BY REGISTRAR DATE NOV 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit; then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

15052

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15055

1. PLACE OF DEATH a. COUNTY <u>BARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Luthicum</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Anundel Hospital</u>		d. STREET ADDRESS <u>427 Greenwood Rd</u>	
3. NAME OF DECEASED (Type or print) <u>BARBARA M. CALLAHAN</u>		4. DATE OF DEATH <u>November 27 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1905</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Quentin</u>		14. MOTHER'S MAIDEN NAME <u>Lessner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-14-5063</u>	
17. INFORMANT <u>Daniel R. Callahan</u>		Address <u>As Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>445X Congestive Heart Failure</u> DUE TO <u>H.A.S.C.U.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-26-</u> , 19 <u>66</u> , to <u>11-27-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-27-</u> , 19 <u>66</u> , and that death occurred at <u>8:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Ignas Saulynas</u>		22b. DATE SIGNED <u>11-27-1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>IGNAS SAULYNAS</u>		22d. ADDRESS <u>319 Old Annapolis Rd Ferndale Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/1/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Howard County, Md.</u>	
24. FUNERAL DIRECTOR <u>Raymond C. Fink</u>		ADDRESS <u>Glen Burnie, Md.</u>	
25a. REC'D BY REGISTRAR <u>Nov 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. J. Jones</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15053

CERTIFICATE OF DEATH

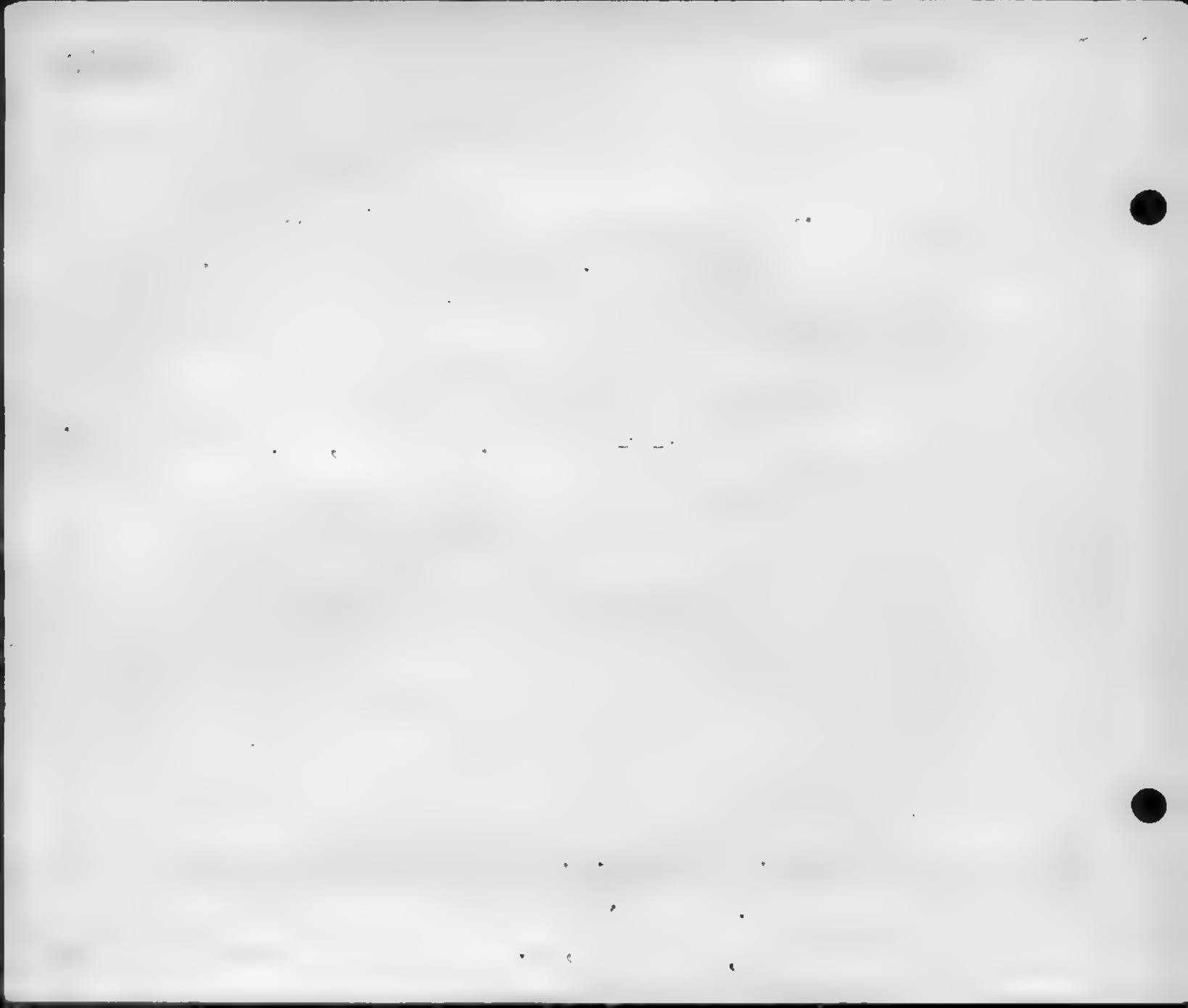
15056

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
c. LENGTH OF STAY IN 1b <u>10 years</u>				d. STREET ADDRESS <u>203 Summit Ave., Marley Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>203 Summit Ave., Marley Park</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jennie M. Carroll</u>				4. DATE OF DEATH <u>Nov. 26, 1966</u>			
5. SEX <u>Female</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>24 April 1885</u>			
9. AGE (In years last birthday) <u>81</u> yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Cadden</u>				14. MOTHER'S MAIDEN NAME <u>Marget Cassidy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-07-7404</u>			
17. INFORMANT <u>Mr. Joseph Lang, 20 W. Furnace Branch Road</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u>							
(c) <u>disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 17, 1966</u> to <u>Nov. 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov. 26, 1966</u> , and that death occurred at <u>11:00 M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Edmond I. Moushabek</u> M.D.				22b. DATE SIGNED <u>28 Nov. 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edmond I. Moushabek, M.D.</u>				22d. ADDRESS <u>510 Marley Station Road, Glen Burnie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>29 Nov. 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Kirkley Funeral Home, Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>NOV 30 1966</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15054

15057

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>77 Pleasant St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William H Carter</u>		4. DATE OF DEATH Month <u>11</u> - Day <u>14</u> Year <u>1966</u>		5. SEX <u>Male</u>			
6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-1897</u>			
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hampton VA U.S.A.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Carter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-01824</u>		17. INFORMANT Address <u>Annex V. Howard, Annapolis</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardio Vascular</u> DUE TO (b) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>November 1966</u> , to <u>11-14</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11-14</u> , 19 <u>66</u> , and that death occurred at <u>5A</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>R. L. Richardson</u>				22b. DATE SIGNED <u>Nov. 14, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>R. L. Richardson, M.D.</u>				22d. ADDRESS <u>110 Clay St., Annapolis, Md., 21401</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 11-17-66</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Lawn Annapolis MD</u>			
23d. LOCATION (City, town or county)		23e. (State)		23f. REC'D BY REGISTRAR			
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		24b. ADDRESS <u>Annapolis</u>		24c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
24d. DATE <u>NOV 15 1966</u>		24e. REGISTRAR'S SIGNATURE					

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

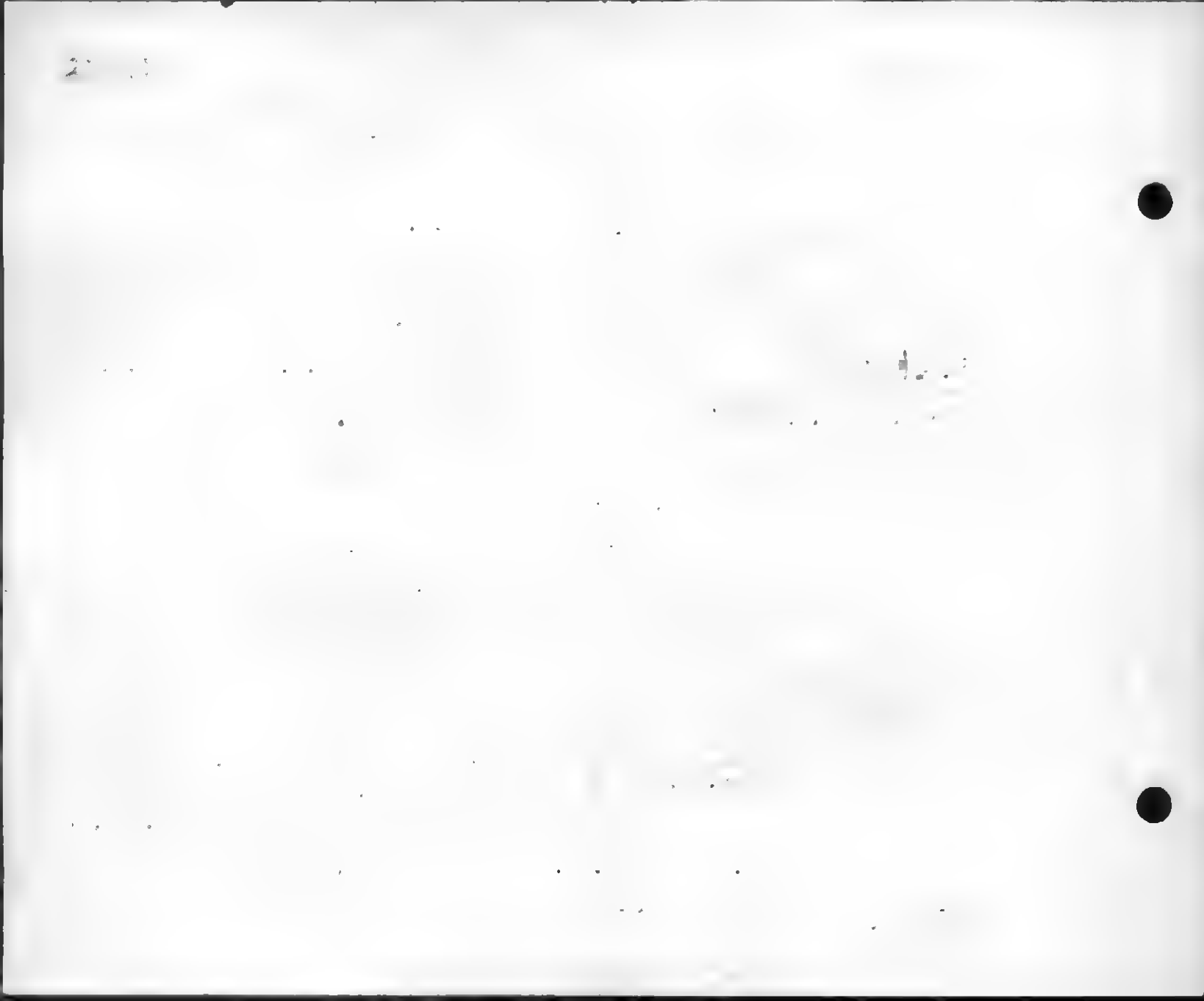
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15055

CERTIFICATE OF DEATH

15058

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS P.O. Box 111		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Edward CHEEK			4. DATE OF DEATH Month Day Year November 9, 19 66				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1904		9. AGE (In years lost birthday) 62 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY P.R.Co.		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES H. CHEEK				14. MOTHER'S MAIDEN NAME IRENE M. WUNDER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT Address FLORA M. CHEEK #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized (metastatic) carcinomatosis DUE TO (c) Adenocarcinoma of prostate gland							INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years 3 years (?)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS A. TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) person attended the deceased from July , 19 65 , to Nov. 9 , 19 66 , that (I) we last saw the deceased alive on Nov. 9 , 19 66 , and that death occurred at 11:10 am M, from causes and on the date stated above.							
22a. SIGNATURE <i>Charles W. Kinzer</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov. 10, 1966			
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22d. ADDRESS South River Medical Center Edgewater, Maryland (21037)					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL	11-12-66	CEDAR HILL		SUITLAND		MD.	
24. FUNERAL DIRECTOR <i>John M. Long</i>		ADDRESS <i>Long & Sons Annapolis, Md.</i>		25a. REC'D BY REGISTRAR DATE NOV 15 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15056

CERTIFICATE OF DEATH

15059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>6408 Fairdel Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jens Martin Christensen</u>		4. DATE OF DEATH <u>Nov. 6, 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 30, 1886</u>	9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u> 10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Denmark</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Don't know</u>		14. MOTHER'S MAIDEN NAME <u>Don't know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. (If yes give war or dates of service) _____		17. INFORMANT Address _____ <u>Mrs. Anna B. Dahlgreen 6408 Fairdel Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio-Vascular Disease</u> <u>4221</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>9-22-1957</u> to <u>11-5-1966</u> that (I) (we) last saw the deceased alive on <u>11-5-1966</u>, and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Milton C. Lang</u> 22c. PHYSICIAN'S NAME (Type) <u>Milton C. Lang</u>		22b. DATE SIGNED M.D. <u>Nov 6 1966</u> 22d. ADDRESS <u>2117 Belair Road</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/10/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road</u>		25a. REC'D BY REGISTRAR <u>NOV 9 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

15057

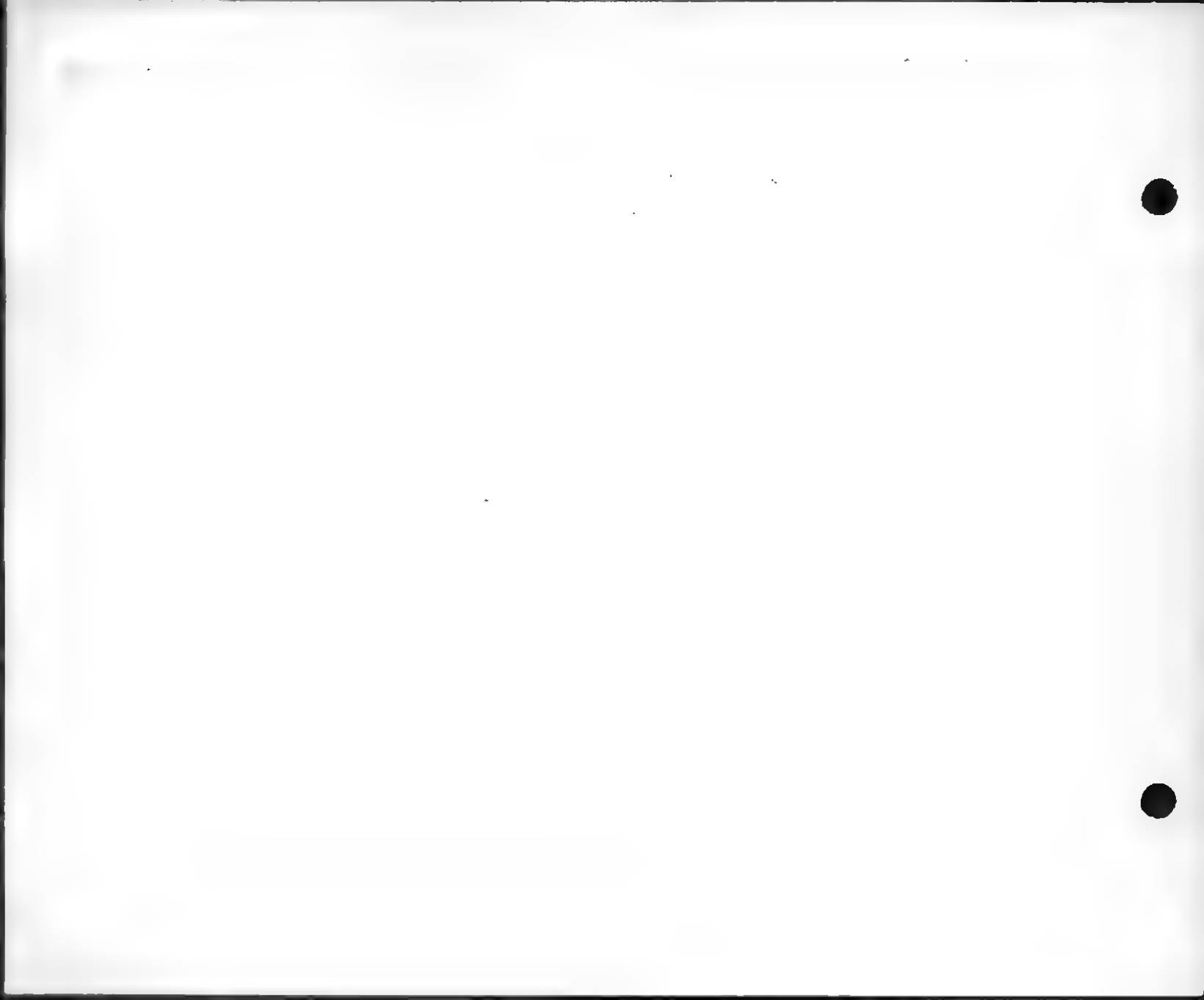
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15060

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>ANCO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>ANCO</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookline</u>		c LENGTH OF STAY IN b <u>25</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. NORTH ARUNDEL HOSP</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>MILTON</u> Middle <u>F</u> Last <u>COLLIER</u>		4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-14-1909</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Neck</u>		10b KIND OF BUSINESS OR INDUSTRY <u>NO. 1 TRANS.</u>	
11 BIRTHPLACE (State or foreign country) <u>KY</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>HERMAN</u>		14 MOTHER'S MAIDEN NAME <u>LILLIAN SUMMERS</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>FAMILY - SAME</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer</u> DUE TO (b) <u>1992</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Interval between onset and death</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. F. Linhardt</u> M.D.		22. DATE SIGNED <u>11/27/66</u>	
EXAMINER'S NAME (Type) <u>E. F. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>11/25/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>	23d LOCATION (City or town) (County) (State) <u>Baltimore</u>
24 FUNERAL DIRECTOR <u>161 E. Foulis</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
25b REGISTRAR'S SIGNATURE		DATE <u>NOV 23 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

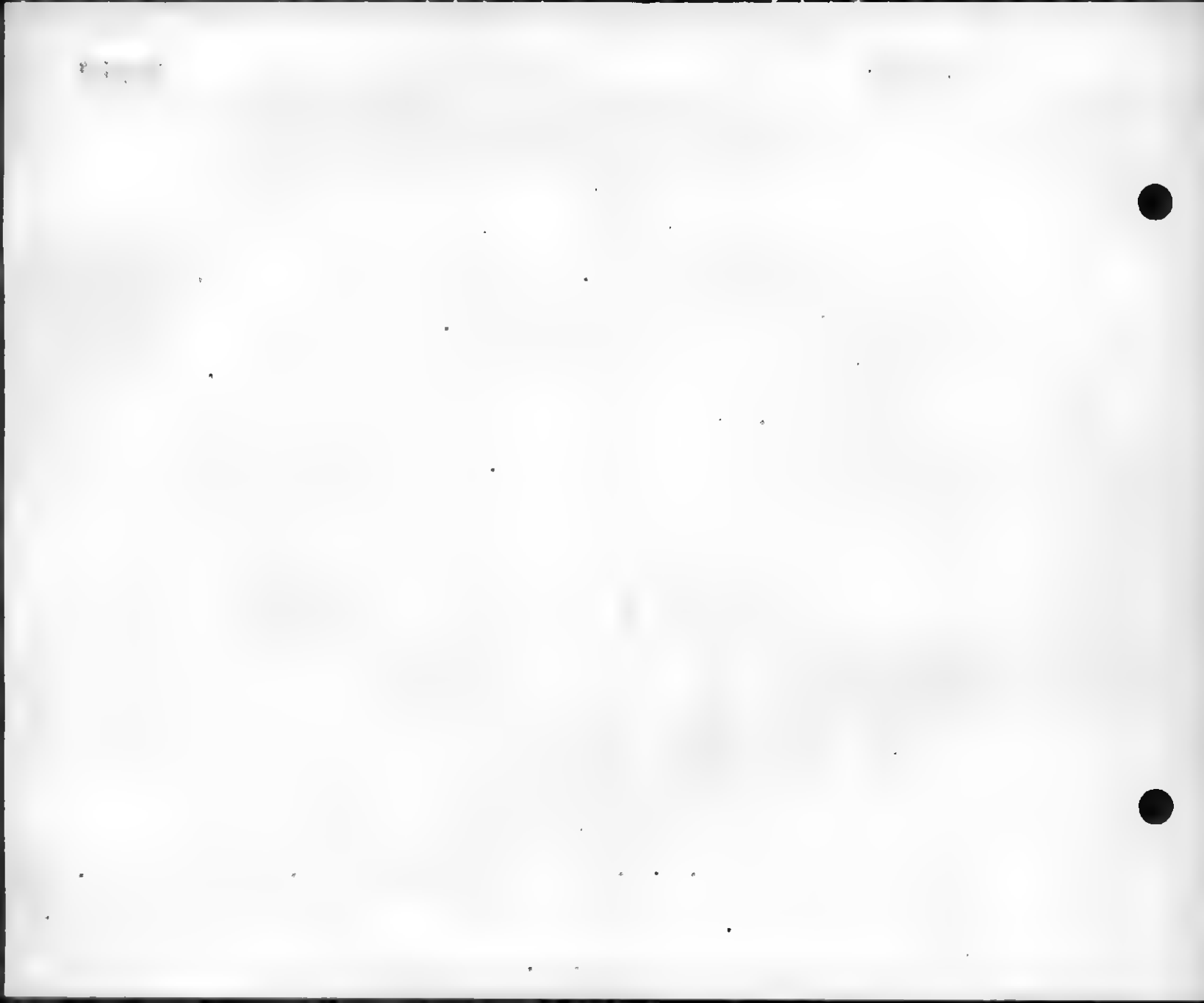
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15058

CERTIFICATE OF DEATH

15061

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 8 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 550 Main Street	
3. NAME OF DECEASED (Type or print) First Marie Middle E. Last Cowan		4. DATE OF DEATH Month Nov. Day 28 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1883
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Abbeville, S. Car.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Preston A. Cheatham		14. MOTHER'S MAIDEN NAME Minnie Brooks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Sarah Rambo, same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4341 Congestive Heart Failure DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-23, 1966 , to 11-28, 1966 , that (I) (we) last saw the deceased alive on 11-28, 1966 , and that death occurred on 11-28, 1966 , from causes on and on the date stated above.			
22a. SIGNATURE Wayne B. Tate, M. D.		22b. DATE SIGNED 11/28/66	
22c. PHYSICIAN'S NAME (Type) Wayne B. Tate, M. D.		22d. ADDRESS 108 Central Ave., Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 30 Nov. 1966	23c. NAME OF CEMETERY OR CREMATORY Long Cane Cemetery	23d. LOCATION (City or Town) (County) (State) Abbeville, South Carolina
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE NOV 30 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

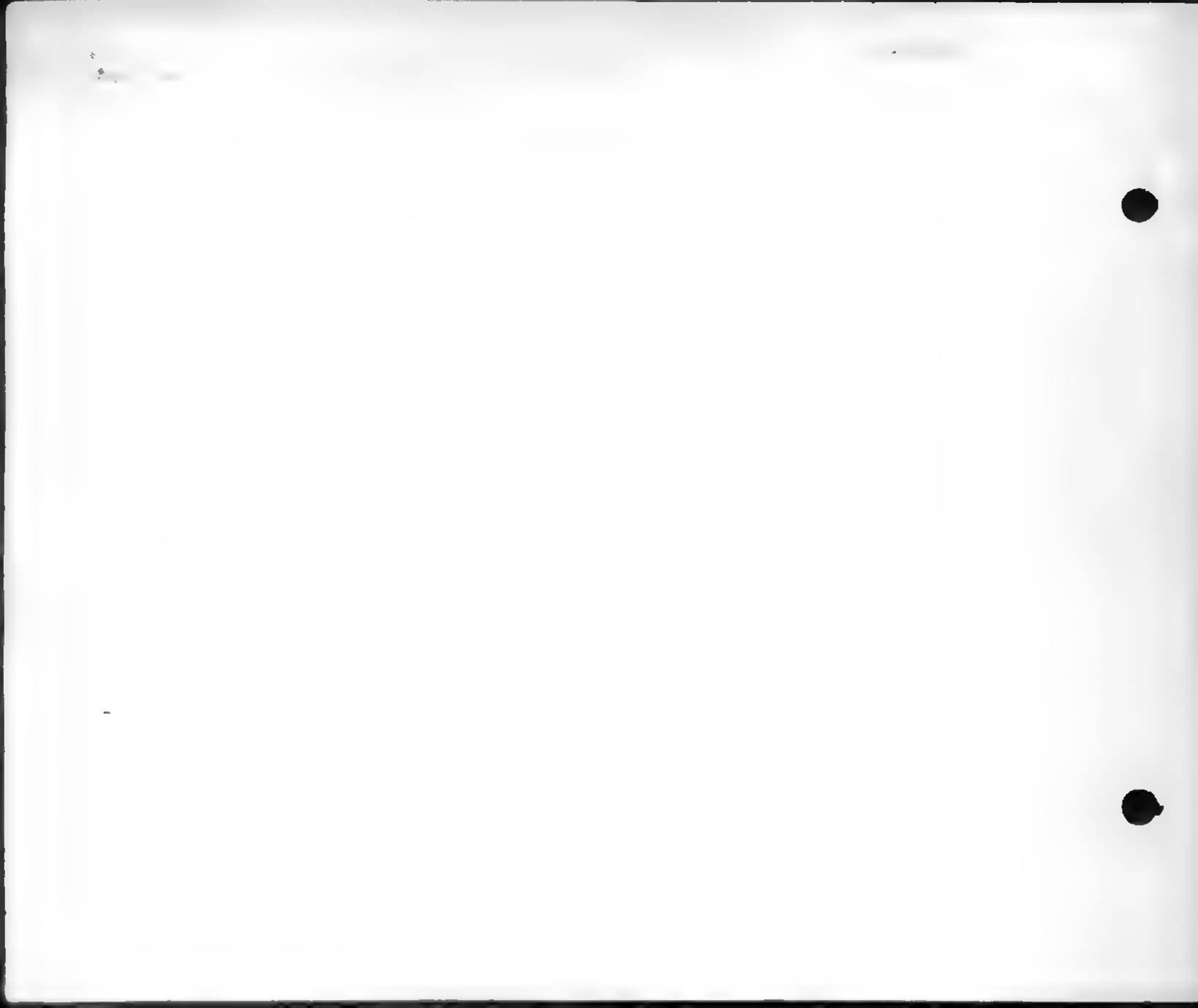
CERTIFICATE OF DEATH

15059

15062

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2

1. NAME OF DECEASED (Type or Print) <i>Helen Regina Cromer</i>		2. DATE AND HOUR OF DEATH <i>11/25/66</i> <i>6⁰⁰ A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ANNE ARUNDEL COUNTY FULL NAME OF HOSPITAL OR INSTITUTION <i>1103 Brooke - Blvd</i> <i>01 Elmer Berne Rd</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ta</i> B. COUNTY <i>Hart</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Hanover</i> D. STREET ADDRESS (If rural, give location) <i>202 Stock Street</i>	
5. SEX <i>F</i>	6. RACE <i>Wh</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Wh</i>	8. DATE OF BIRTH <i>4/27/1914</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laundry Co</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>dress Mfg</i>	9. AGE (In years last birthday) <i>52</i>
11. BIRTHPLACE (State or foreign country) <i>Illinois Co. Ill</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Frank Gimple</i>		14. MOTHER'S MAIDEN NAME <i>Lincoln Hanover</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>185-34-8807</i>	
17. INFORMANT <i>Mrs Richard Gajon</i>		18. ADDRESS <i>1103 Brooke Blvd</i>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>17th ANTECEDENT CAUSES</i>		20. CAUSE OF DEATH (A) <i>Congestive Heart Failure</i> (B) <i>Generalized Carcinoma</i> (C) <i>Primary Breast Carcinoma</i>	
21. INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	
23. I certify that (I) (this hospital) attended the deceased from <i>11/20</i> 1966 to <i>11/25</i> 1966 that (I) (we) last saw the deceased alive on <i>11/25</i> 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
24A. SIGNATURE <i>James N. Frederick</i>		24B. DATE SIGNED <i>11/25/66</i>	
25A. PHYSICIAN'S NAME (Type) <i>James N. Frederick</i>		25B. ADDRESS <i>1311 Francis Ave Baltimore Md, 21227</i>	
26A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		26B. DATE <i>11/20/66</i>	
27A. NAME OF CEMETERY OR CREMATORY <i>Wt Mount</i>		27B. LOCATION (City, town, or county) <i>Hanover York Co</i>	
28A. DATE REC'D BY HEALTH DEPT <i>NOV 30 1966</i>		28B. NAME OF REGISTRAR <i>Charles Judge</i>	
29A. FUNERAL DIRECTOR <i>Wm H. Keen</i>		29B. ADDRESS <i>264 Franklin St Hanover</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15060

15063

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>52 Shaw</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry Crocker</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-15-1891</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>25</u> IF UNDER 24 HRS.: Hours <u>11</u> Min. <u>11</u>		4. DATE OF DEATH <u>11-11-1966</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tom Crocker</u> 14. MOTHER'S MAIDEN NAME <u>Lisa Crocker</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>100-1-100000</u> 17. INFORMANT <u>Mary E. Tinsley</u> Address <u>Annapolis MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5-866</u> 20f. (City or town) <u>11-11-66</u> (County) <u></u> (State) <u></u>			
21. I certify that (I) (this hospital) attended the deceased from <u>5-866</u> , 19 <u>66</u> , to <u>11-11-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-10-66</u> , 19 <u>66</u> , and that death occurred at <u>11-11-66</u> , 19 <u>66</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>A. T. Allen</u> 22c. PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		22b. DATE SIGNED <u>6-1 October 4</u> 22d. ADDRESS <u>61 Crocker St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 11-15-66</u> 23b. DATE THEREOF <u>11-15-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> 23d. LOCATION (City, town or county) <u>Annapolis MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> Address <u>Annapolis MD</u>		25a. REC'D BY REGISTRAR <u>Charles J. Jones</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u> DATE <u>NOV 15 1966</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

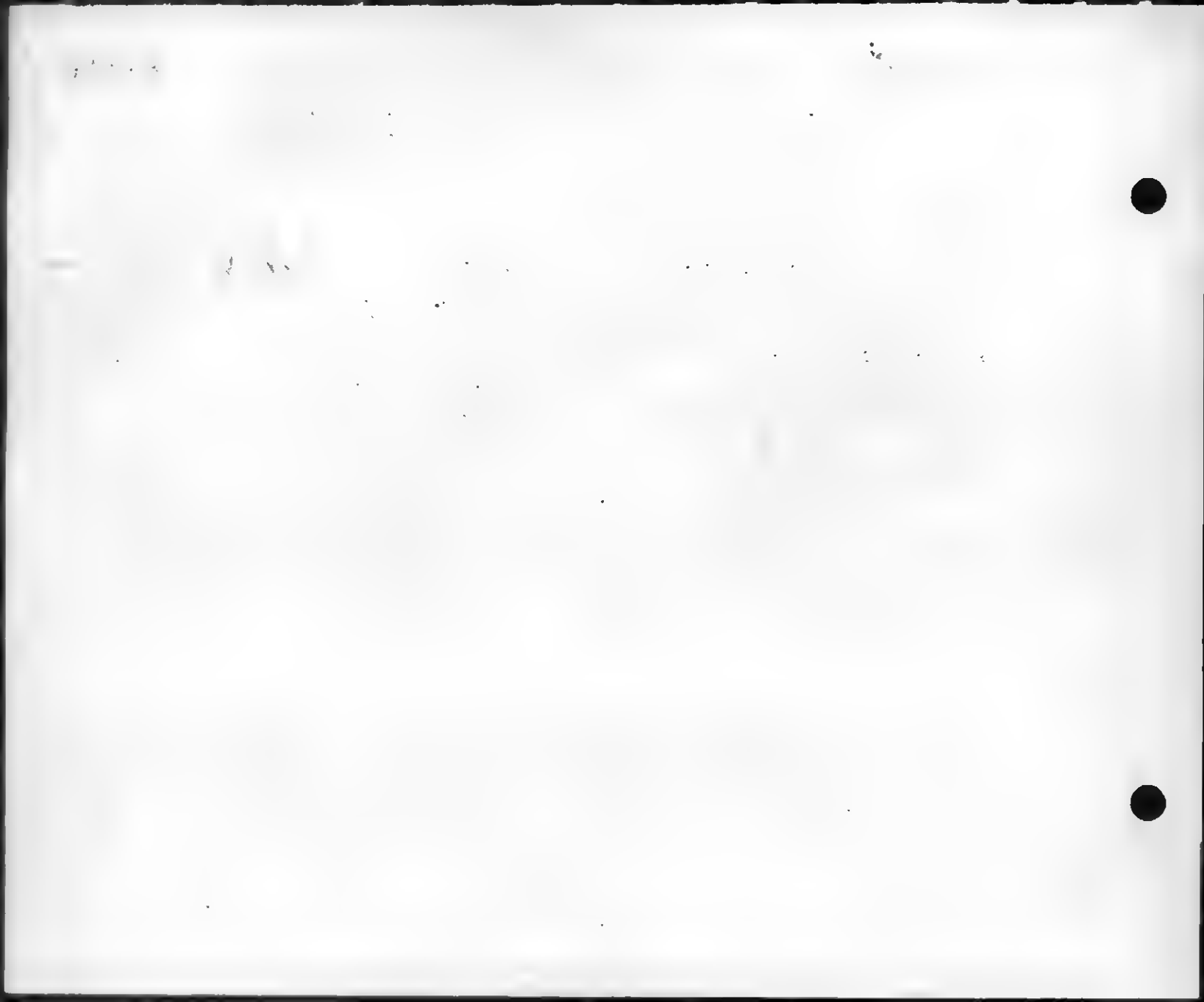
FOR STATE
HEALTH DEPT.

15061

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15064

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A.A. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>203 LOCKWOOD COURT</u>	
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>R.</u> Last <u>Deale</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 9, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTING CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAINTING</u>	9. AGE (In years last birthday) <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>DEALE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PEYTON A. DEALE</u>		14. MOTHER'S MAIDEN NAME <u>GRACE OLIVE PRICE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII</u>		17. INFORMANT <u>DOLORES C. DEALE #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>11-10-66</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-13-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEM.</u>	23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR</u>		25a. REC'D BY REGISTRAR <u>NOV 15 1966</u>	
ADDRESS <u>SON 9 ANNAPOLIS MD</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

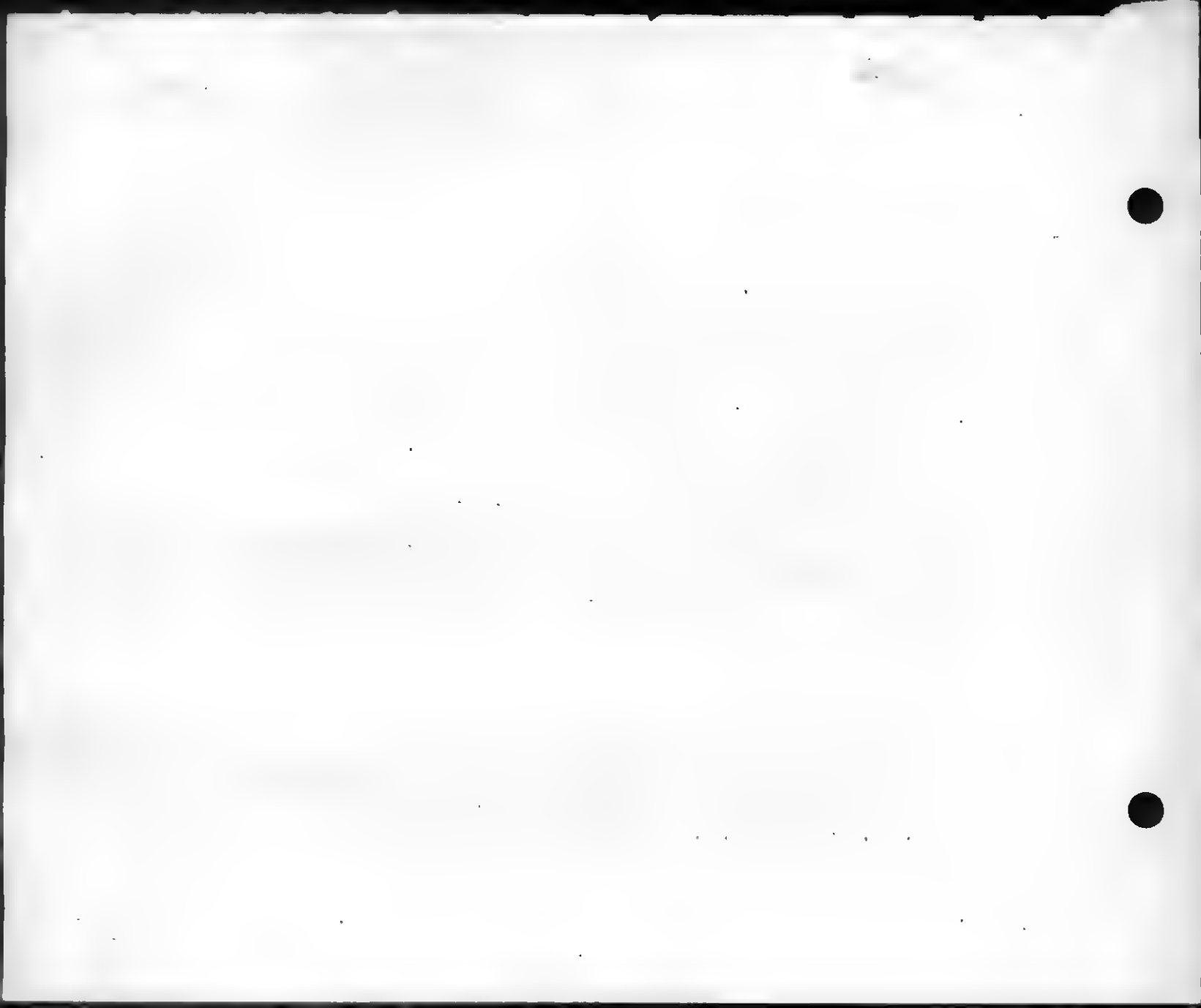
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15062

CERTIFICATE OF DEATH

15065

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry W.</u> Middle <u>Diffendall</u> Last <u></u>		4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1892</u>
9. AGE (in years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glass House</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilbert Diffendall</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Wilbert T. Diffendall</u>		Address <u>Box 126 B Ridge Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic CVRD</u> (c) <u>Diabetes Mellitus- controlled</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> duration <u>15-20 yr.</u> <u>8yr + or -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> , 19 <u>66</u> , to <u>11/15</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11/12</u> , 19 <u>66</u> , and that death occurred at <u>12 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R. V. Rangle M.D.</u>		22b. DATE SIGNED <u>11/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. V. Rangle</u>		22d. ADDRESS <u>2938 St. Paul St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/18/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Amber Inc. 1328 Sulphur Sp Rd.</u>		25a. REC'D BY REGISTRAR <u>NOV 21 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15ME (5)
6M 1/66

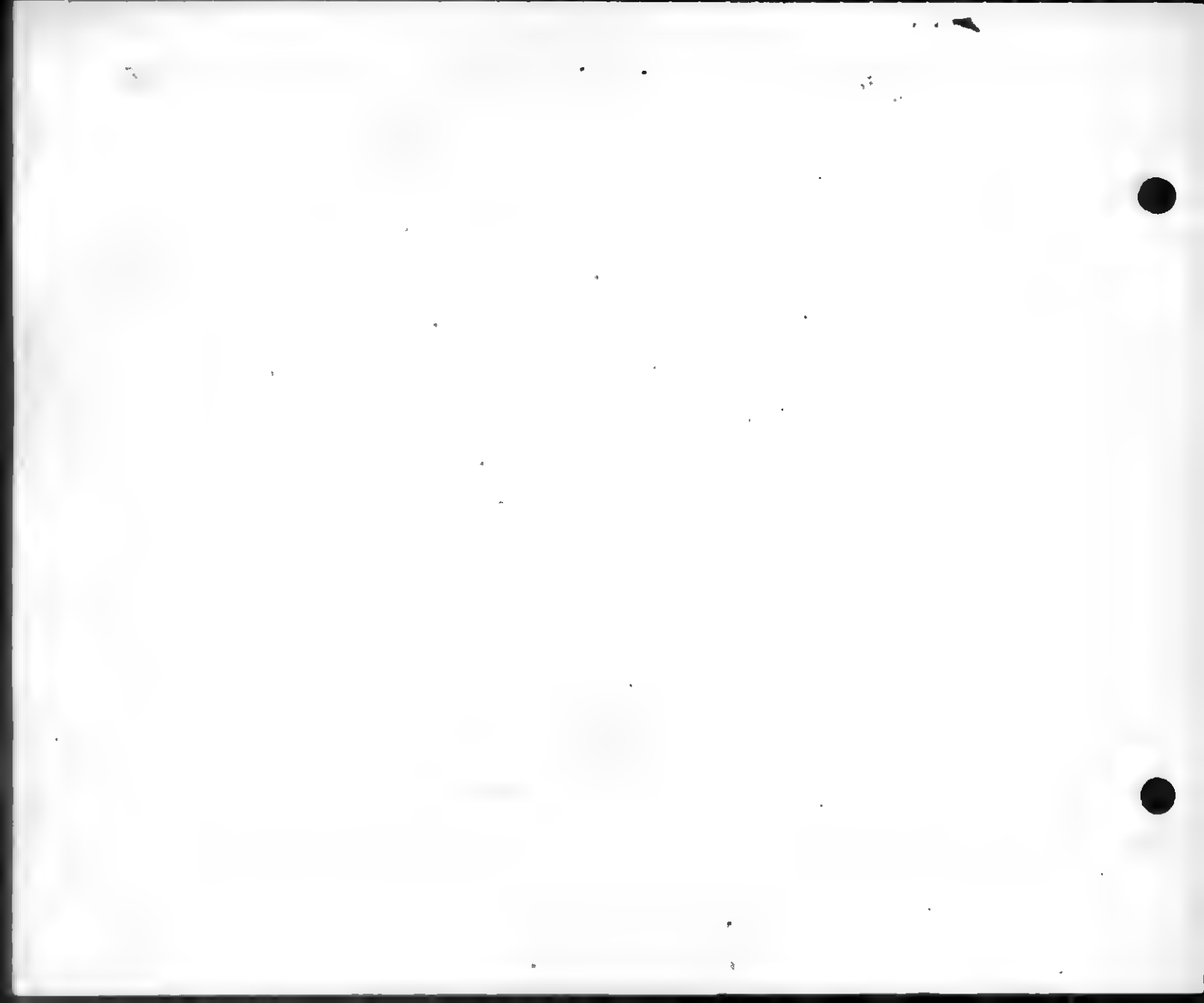
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15066

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c LENGTH OF STAY IN b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital				a STREET ADDRESS Rt. 2, Box 21		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last EDWARD W. DUVALL				4 DATE OF DEATH Month Day Year 11 11 19 66			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 28 Feb. 1903		9 AGE (in years, last birthday) 63 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b KIND OF BUSINESS OR INDUSTRY Own Farm		11 BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Richard I. Duvall				14 MOTHER'S MAIDEN NAME Mary E. Whittington			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO		17 INFORMANT Address Mr. Ernest Duvall, Severna Park, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot Wound of Head 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self in head					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11/11 19 66		20d INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) tavern		20f (City or town) (County) (State) Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion on death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 11/12/66	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 15 Nov. 1966		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore 25, Md.	
24 FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md.				25a REC'D BY REGISTRAR DATE NOV 15 1966		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15064

CERTIFICATE OF DEATH

15067

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 Month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Box 37 Rt. 2, Old Annapolis Rd.	
3. NAME OF DECEASED (Type or print) First James Middle MMN Last EVANS		4. DATE OF DEATH Month November Day 5 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1901
9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Luther Evans		14. MOTHER'S MAIDEN NAME Martha Evans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-5107	
17. INFORMANT Elizabeth M. Evans		Address Rt2 Box 37 Severna Pk, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bleeding Peptic ulcer DUE TO 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) 2 days DUE TO (c) 2 days		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-26-66 , 19__, to 11-5-66 , 19__, that (I) (we) last saw the deceased alive on 11-5-66 , 19__, and that death occurred at 4:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE A. Allen		22b. DATE SIGNED 11-7-66	
22c. PHYSICIAN'S NAME (Type) A. ALLEN		22d. ADDRESS 61 Chelmsford St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/9/66	23c. NAME OF CEMETERY OR CREMATORY Town Neck Church	23d. LOCATION (City or Town) (County) (State) Anne Arundel Md
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Maryland		25. REC'D. BY REGISTRAR Nov 14 1966	
26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15065

CERTIFICATE OF DEATH

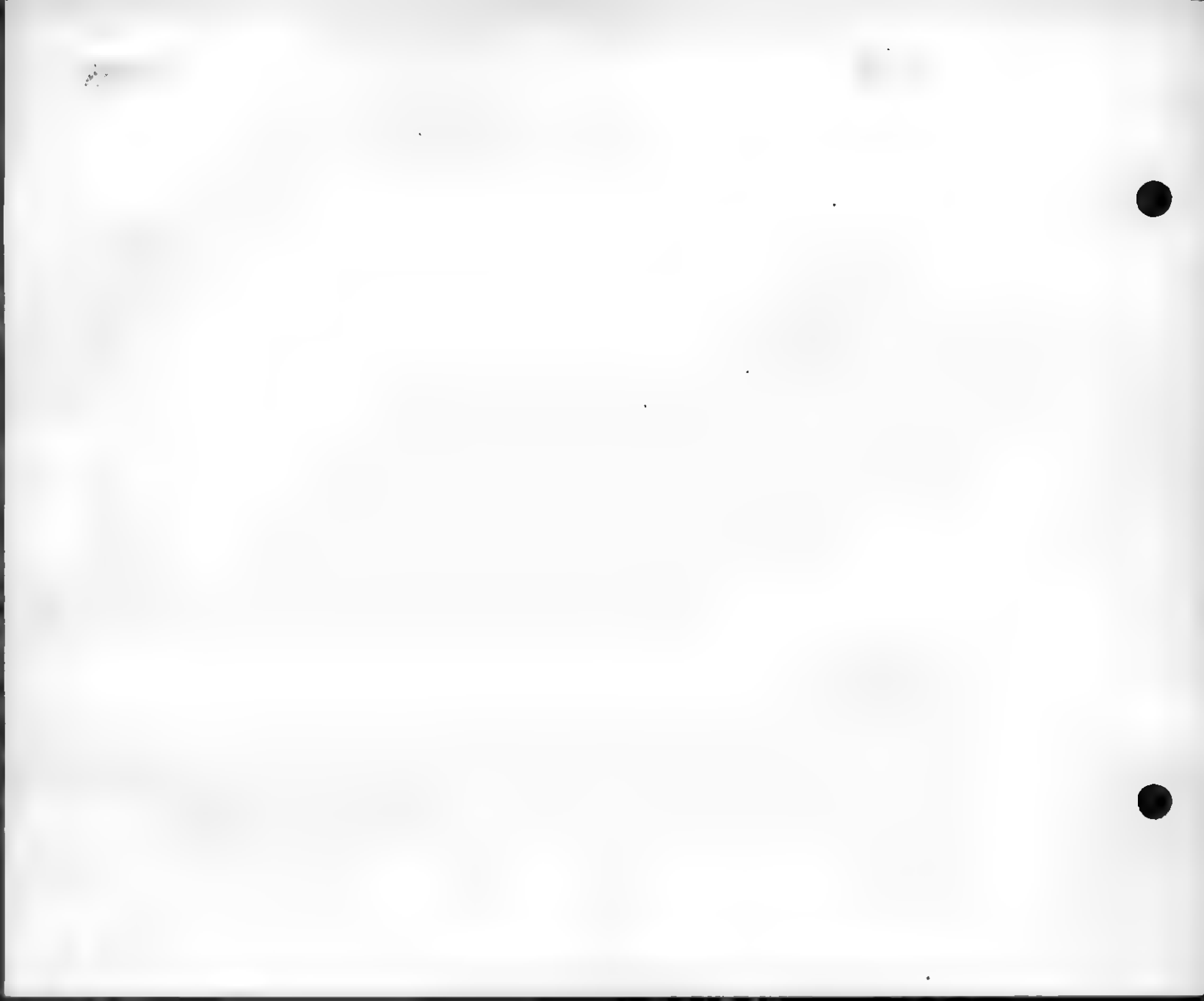
15068

1 PLACE OF DEATH a COUNTY <u>Ad. A.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>MD</u> b COUNTY <u>Ad. A.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c LENGTH OF STAY IN 3b <u>Annapolis</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ad. A. General</u>		d STREET ADDRESS <u>710 2nd St Eastport</u>	
3 NAME OF DECEASED (Type or print) <u>Mollie</u> First <u>Evans</u> Middle Last		4 DATE OF DEATH Month <u>11</u> - Day <u>24</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-30-1929</u>
9. AGE (In years last birthday) <u>37</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Byrd</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Mrs Evans 710 2nd St</u>		Address	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac arrest due to endotoxic shock &</u> DUE TO <u>acute pyelonephritis & obstructed ureter</u> (b) <u> </u> DUE TO <u>bilateral tubo-ovarian abscess (pyosalpinx) &</u> (c) <u>extensive pelvic cellulitis & uterine fibroid</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town)		(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>66</u> , to <u>11/24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/24</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> P.M., from causes and on the date stated above.		
22a. SIGNATURE <u>W. Bonnell</u>	M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)	22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY
<u>Buried</u>	<u>11-28-1966</u>	<u>Adams</u>
23d LOCATION (City or Town)	(County)	(State)
<u>Lebanon</u>	<u>MD</u>	<u> </u>
24 FUNERAL DIRECTOR <u>William Reese & Co. Inc. Inc.</u>	25a. REC'D BY REGISTRAR DATE <u>NOV 25 1966</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15066

CERTIFICATE OF DEATH

16523

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G. MEADE			c. LENGTH OF STAY IN 1b 51 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G. MEADE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				d. STREET ADDRESS 7334-A KELLY LOOP		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PEGGIE JOYCE ADAMS EVANS				4. DATE OF DEATH Month Day Year NOVEMBER 30 19 66			
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 DEC 1935		9. AGE (In years last birthday) 30 yrs	f. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Selma Dallas, Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emmett L. Adams				14. MOTHER'S MAIDEN NAME Lorena L. Wheeler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No N/A		16. SOCIAL SECURITY NO. 418-42-0824		17. INFORMANT Address Ft Geo G. Meade, Md William Evans, 7334-A Kelly Loop			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190.9 METASTATIC DISEASE TO BRAIN DUE TO (b) MALIGNANT MELANOMA DUE TO (c) BRONCHO PNEUMONIA CHRONIC PYELONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH 1 YEAR 18 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 Sept , 19 66 , to 30 Nov , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 30 Nov 19 66 , and that death occurred at 4:20 M. from causes and on the date stated above.							
22a. SIGNATURE Carl S. Rosen				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 30 Nov 66	
22c. PHYSICIAN'S NAME (Type) CARL S. ROSEN, CPT, MC				22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF December 5, 1966		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM, ARLINGTON, VIRGINIA		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR Harold S. Meade, Samuel, Inc.				25a. REC'D BY REGISTRAR DATE DEC 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

(1000)

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit if it is used for a funeral. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and of any event within 72 hours after death.

VR A15ME (F)
6M 1/66

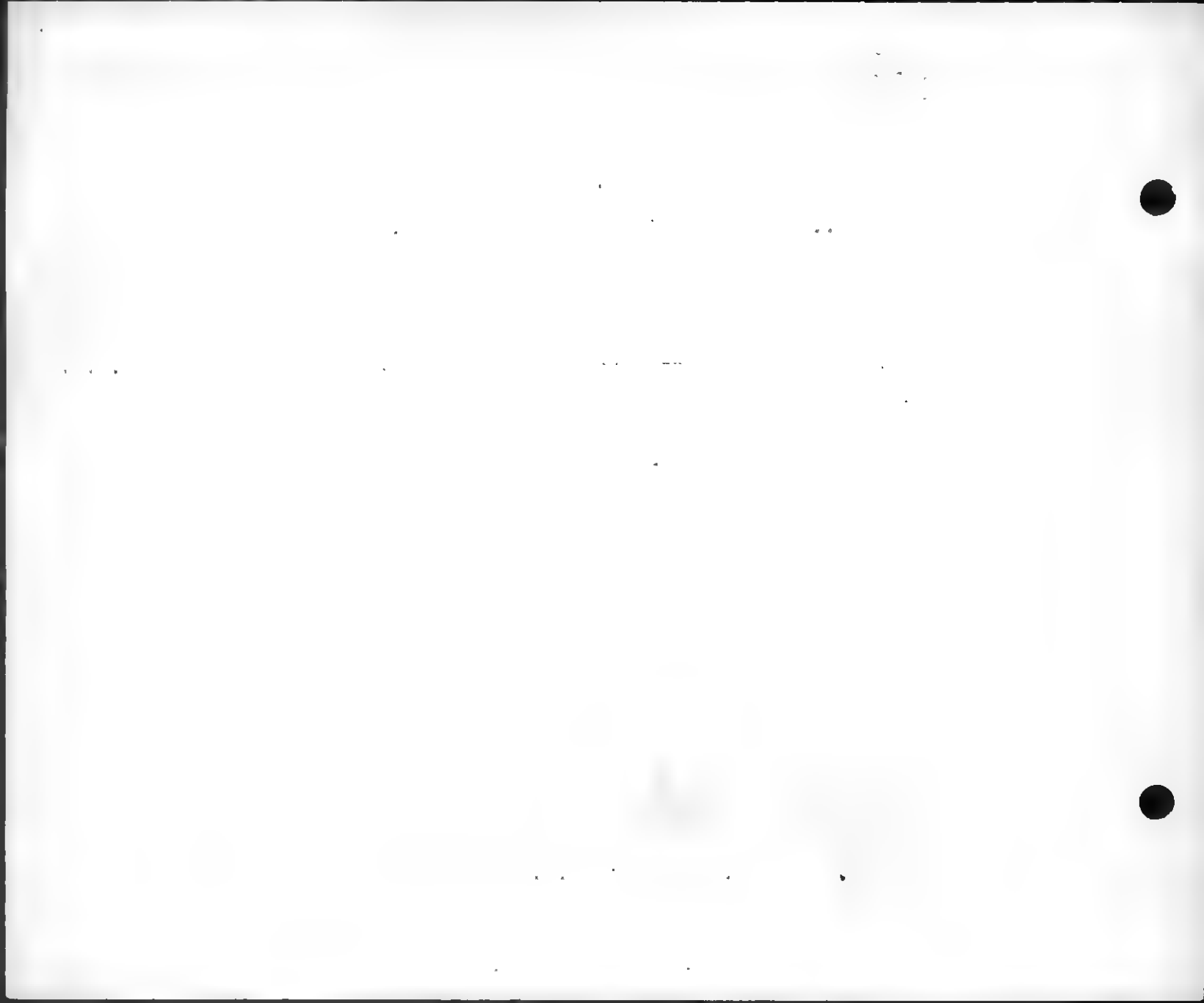
15067

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16524

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Baltimore City			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c LENGTH OF STAY IN 1b 3mos. 21days		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d STREET ADDRESS 613 E. Baltimore Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #32865 Andrew Fanny				4. DATE OF DEATH Month 11 Day 24 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 4, 1911	9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 11 Days 24 Hours 19 Min 66		11. IF UNDER 24 HRS Months 11 Days 24 Hours 19 Min 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Stock Clerk		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Norfolk, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Fanny				14. MOTHER'S MAIDEN NAME Goodman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 225-28-8897		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Alcoholic Intoxication 322.1 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Alcoholism DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH One week Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month Day, Year Hour am -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Elmer G. Linhardt, M.D. M.D.				22. DATE SIGNED 11-24-66			
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11/21/66		23c. NAME OF CEMETERY OR CREMATORY UNIV. MD		23d. LOCATION (City or Town) (County) (State) BALIT. MD.	
24. FUNERAL DIRECTOR William Reese II 108 W. Washington St.				25a. REC'D BY REGISTRAR DEC 2 1966		25b. REGISTRAR'S SIGNATURE -----	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

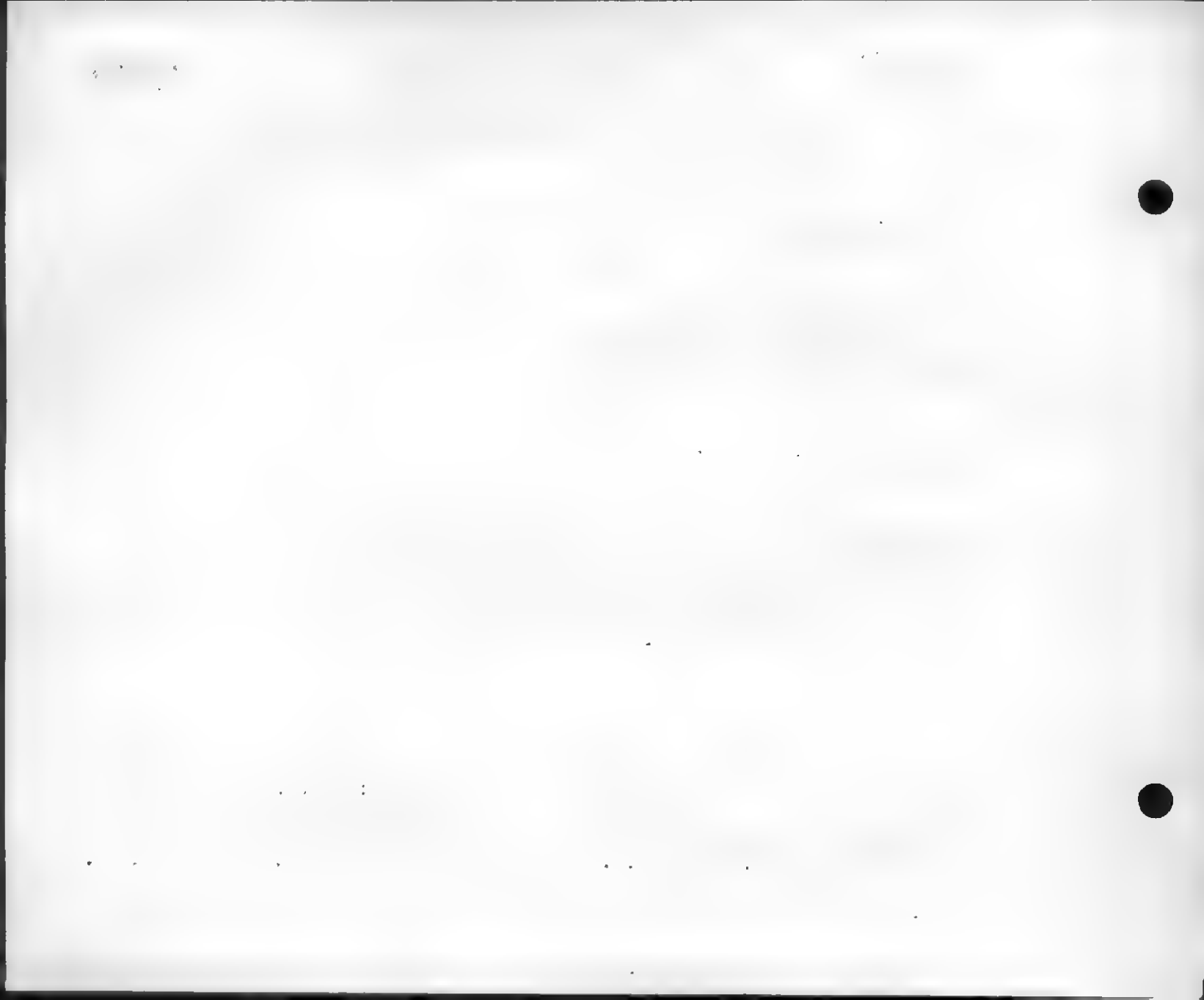
15068

CERTIFICATE OF DEATH

15069

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Rt. 1, Box 74B		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Hazel Last FENNER				4. DATE OF DEATH Month November Day 12 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1918	9. AGE (in years last birthday) 48 yrs	IF UNDER 1 YEAR Months 4 Days 12 Hours 12 Min 00	IF UNDER 24 HRS Months 0 Days 12 Hours 12 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ceremonial Work Printing Co		10b. KIND OF BUSINESS OR INDUSTRY Ceremonial Work Printing Co		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank Reisch				14. MOTHER'S MAIDEN NAME Clara Weaver			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220 055 747		17. INFORMANT George L. Fenner, Jr. Address Severna Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 331X DUE TO (c) 331X						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Cerebral Vascular Accident - Hypertension						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Dr. William F. Krone attended the deceased from 1966 , to 1966 , that (I) last saw the deceased alive on 1966 , and that death occurred at 3:50 A.M. from causes and on the date stated above.							
22a. SIGNATURE William F. Krone, M.D.				22b. DATE SIGNED NOV 17 1966		22c. PHYSICIAN'S NAME (Type) William F. Krone, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 11/15/66		23c. NAME OF CEMETERY OR CREMATORY Greenwood Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR Robert S. Barranco				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

ROBERT S. BARRANCO



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15069

CERTIFICATE OF DEATH

15070

1. PLACE OF DEATH a. COUNTY <u>Rownsville State Hosp</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>3507 Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crown St. State Hosp</u>				d. STREET ADDRESS <u>518 N. Decker Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>VALENTINE Fischer</u>				4. DATE OF DEATH 8-25-66			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7.14.11</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days		10. IF UNDER 24 HRS. Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN C. FISHER</u>				14. MOTHER'S MAIDEN NAME <u>BERNARDINE (Fischer) Wilgen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>2129 5052</u>		17. INFORMANT <u>Andrew H. Fischer 3507 Belair Road</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Rupture</u> DUE TO (b) <u>Hypertensive Encephalopathy</u> DUE TO (c) <u>354X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>8/9/66</u> , 19 <u>66</u> , to <u>8/25/66</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>8/25/66</u> , 19 <u>66</u> , and that death occurred at <u>8:00</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>L. BENEDICT M.D.</u>				22b. DATE SIGNED <u>8/25/66</u>		22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or placement, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15070

15071

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN ab <u>D.O.H.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.C. Co. Gen. Hospital</u>				d. STREET ADDRESS <u>1003 Box 302</u>			
3. NAME OF DECEASED (Type or print) <u>JAMES F. FITZSIMMONS</u>				4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-89</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas + Elect. Co</u>		11. BIRTHPLACE (County & State, or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James J. Fitzsimmons</u>				14. MOTHER'S MAIDEN NAME <u>Bridgett Fuberty</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Edith Fitzsimmons</u>		Address <u>Alone</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary arteriosclerotic heart disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> , 19 <u>56</u> , to <u>11/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/7</u> , 19 <u>66</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>R.M. McLaughlin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/21/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>				22d. ADDRESS <u>3708 Mountain Road, Pasadena, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11/23/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Harmon Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Allyn Barncie Md</u>	
24. FUNERAL DIRECTOR <u>Robert S. Barncie</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G-82, 11/14/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

150771

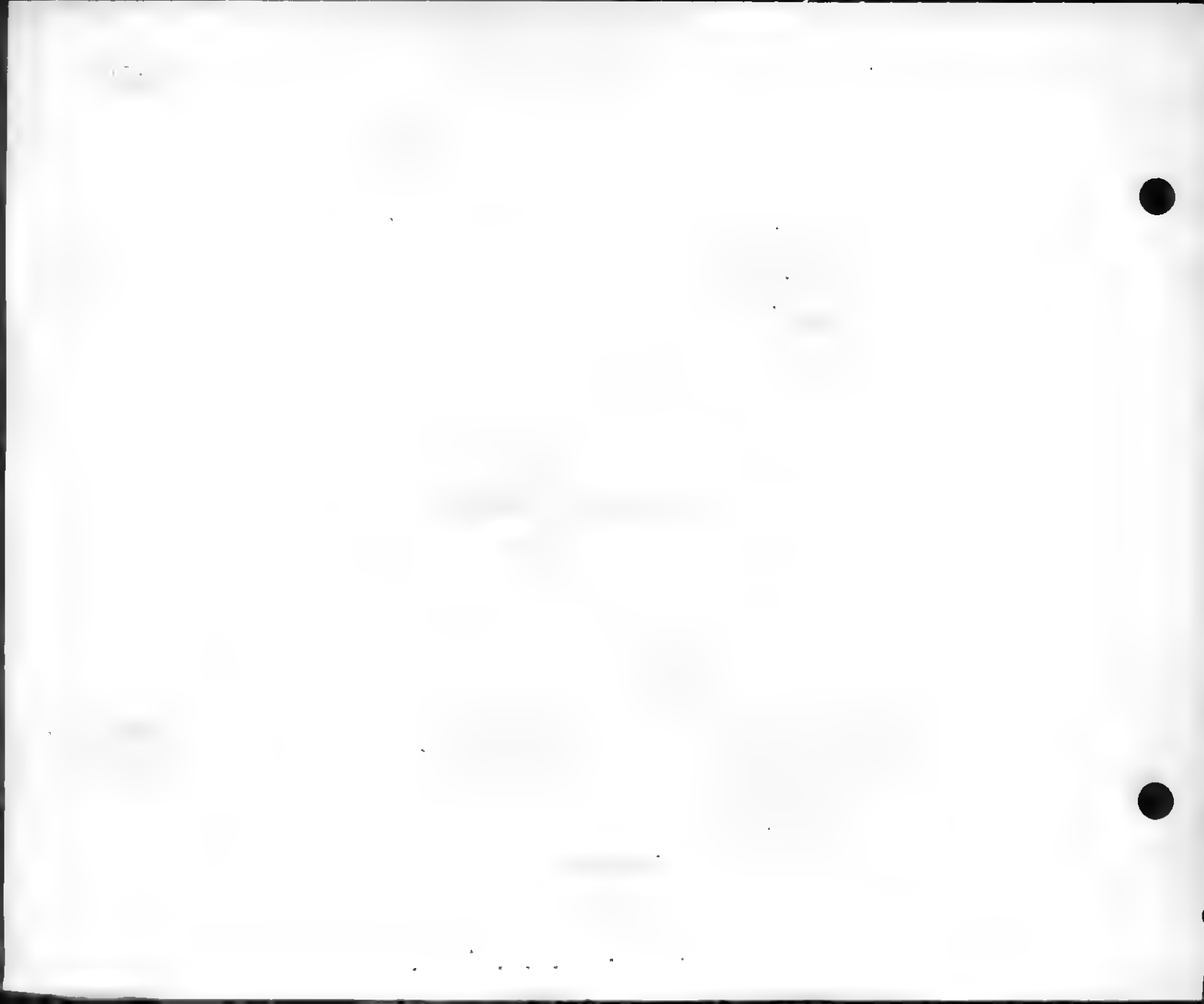
150772

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>A.A.Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>WASH.D.C.</u> b COUNTY <u>✓</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. General Hosp.</u>		d STREET ADDRESS <u>2533 Waterside Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Kitty B. Frank</u>		4 DATE OF DEATH Month <u>11</u> Day <u>✓</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 3+11-1922</u> AGE (In years last birthday) <u>44</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Lawyer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Harry Edwin Blair</u>		14 MOTHER'S MAIDEN NAME <u>Lucy Rachel Stiegers</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>—</u>	
17 INFORMANT <u>Robert B. Frank - See Item #2.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - Rt. 50 -</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11/2</u> AM <u>11/2</u> PM <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>A.A.Co. MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u>		22. DATE SIGNED <u>11-5-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11-5-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory Suitland, Md.</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25. REC'D BY REGISTRAR <u>NOV 7 1966</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

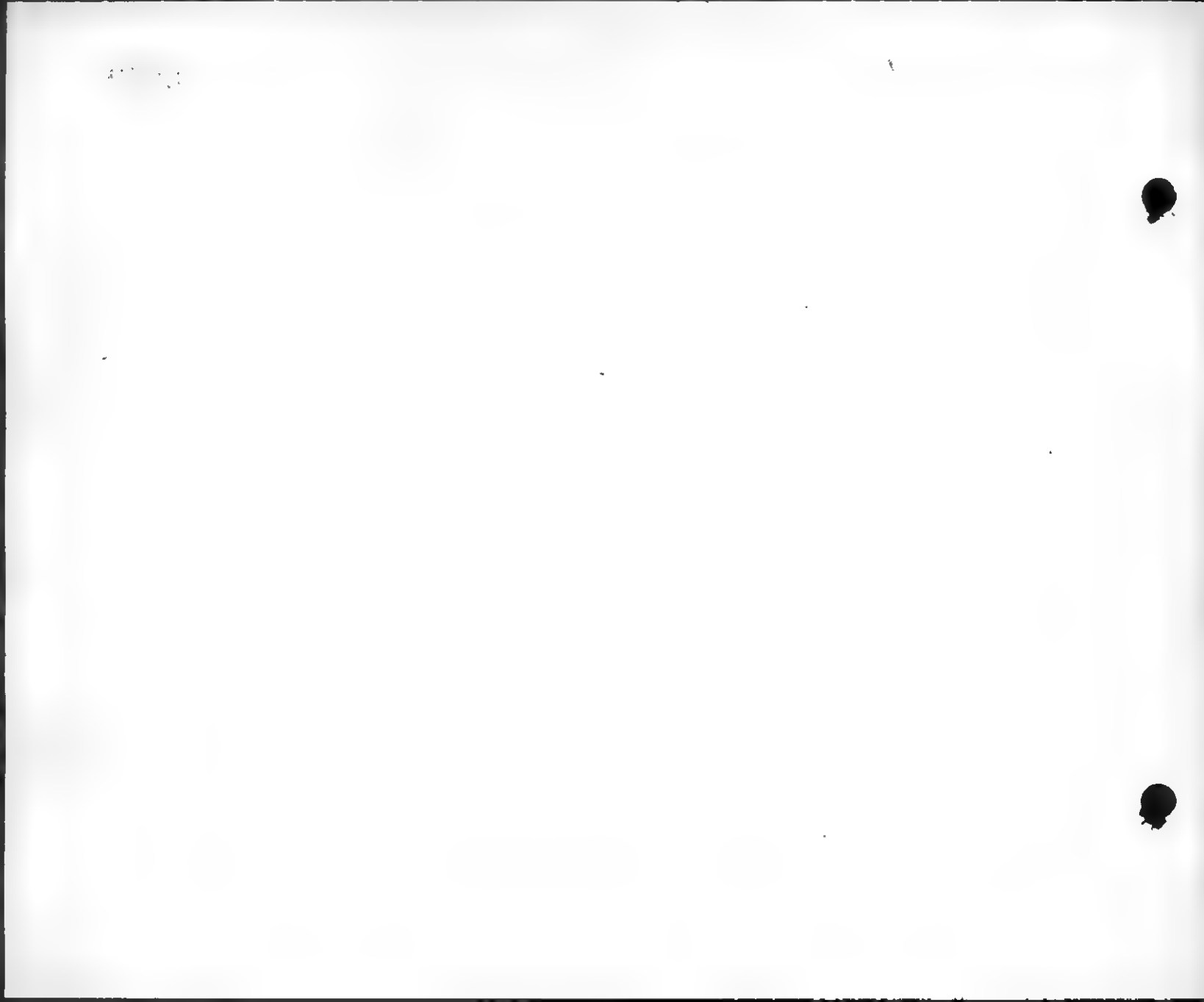
VR A15ME
6M 1/66

15072

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15073

1 PLACE OF DEATH a COUNTY <u>Prince Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b. COUNTY <u>A. Arundel</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c LENGTH OF STAY IN TB <u>1 hr</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOH-NORTH ARUNDEL-HOSPITAL</u>		e STREET ADDRESS <u>PASADENA-MD</u>	
3 NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>K</u> Last <u>Garrett</u>		4 DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/20/1897</u>
9 AGE (In years lost birthday) <u>69</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11 BIRTHPLACE (State or foreign country) <u>N.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John J. Garrett</u>		14 MOTHER'S MAIDEN NAME <u>Sarah Garrett</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>214-03-3008</u>	
17 INFORMANT <u>Mrs. Lillian Garrett</u>		Address <u>Pasadena, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		22. DATE SIGNED <u>11-23-66</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11-28-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>Harry W. Knight</u>		25a RECD BY REGISTRAR <u>Sylkesville, Md.</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 28 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach pages 1 and 2. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

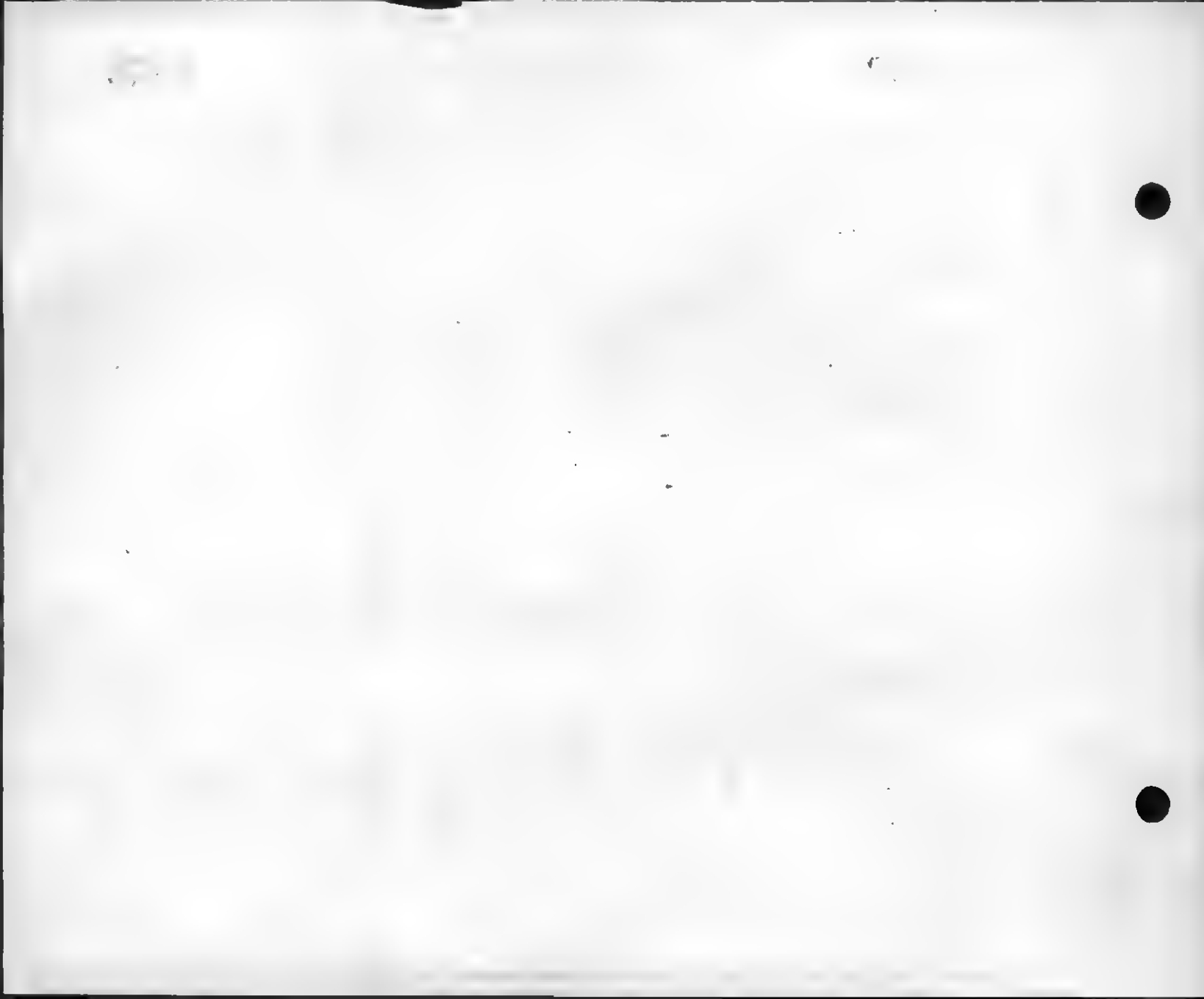
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15073

CERTIFICATE OF DEATH

15074

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 1902 Crain Highway	
3. NAME OF DECEASED (Type or print) First Middle Last Henry M Gerber		4. DATE OF DEATH Month Day Year November 6 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Feb. 25, 1900
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		12. KIND OF BUSINESS OR INDUSTRY Retired	
13. BIRTHPLACE (County & State, or foreign country) Pennsylvania		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME CALVIN M.		16. MOTHER'S MAIDEN NAME VIOLA CHRONISTER	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		18. SOCIAL SECURITY NO. 217-07-1097	
19. INFORMANT CALVIN M. GERBER		Address GLEN BURNIE, MD.	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular accident DUE TO (b) Chronic Heart Failure DUE TO (c) arteriosclerotic Heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 days months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour, a.m. p.m. 11/4/66 11:20 a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/4/66 , 19__ to 11/6/66 , 19__, that (I) (we) last saw the deceased alive on 11/5/66 , 19__, and that death occurred at 11:20 a.m. from causes and on the date stated above.			
22a. SIGNATURE J. B. Ramirez		22b. DATE SIGNED 11/6/66	
22c. PHYSICIAN'S NAME (Type) J. B. RAMIREZ MD		22d. ADDRESS 3427 ANNAPOLIS RD Bldg 29 1672 NORTHBOURNE RD Bldg 12	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-9-1966	
23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		23d. LOCATION (City or Town) (County) (State) YORK YORK PA.	
24. FUNERAL DIRECTOR Henry F. Dodson Jr.		25a. REC'D BY REGISTRAR DATE NOV 10 1966	
ADDRESS York, Pa.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

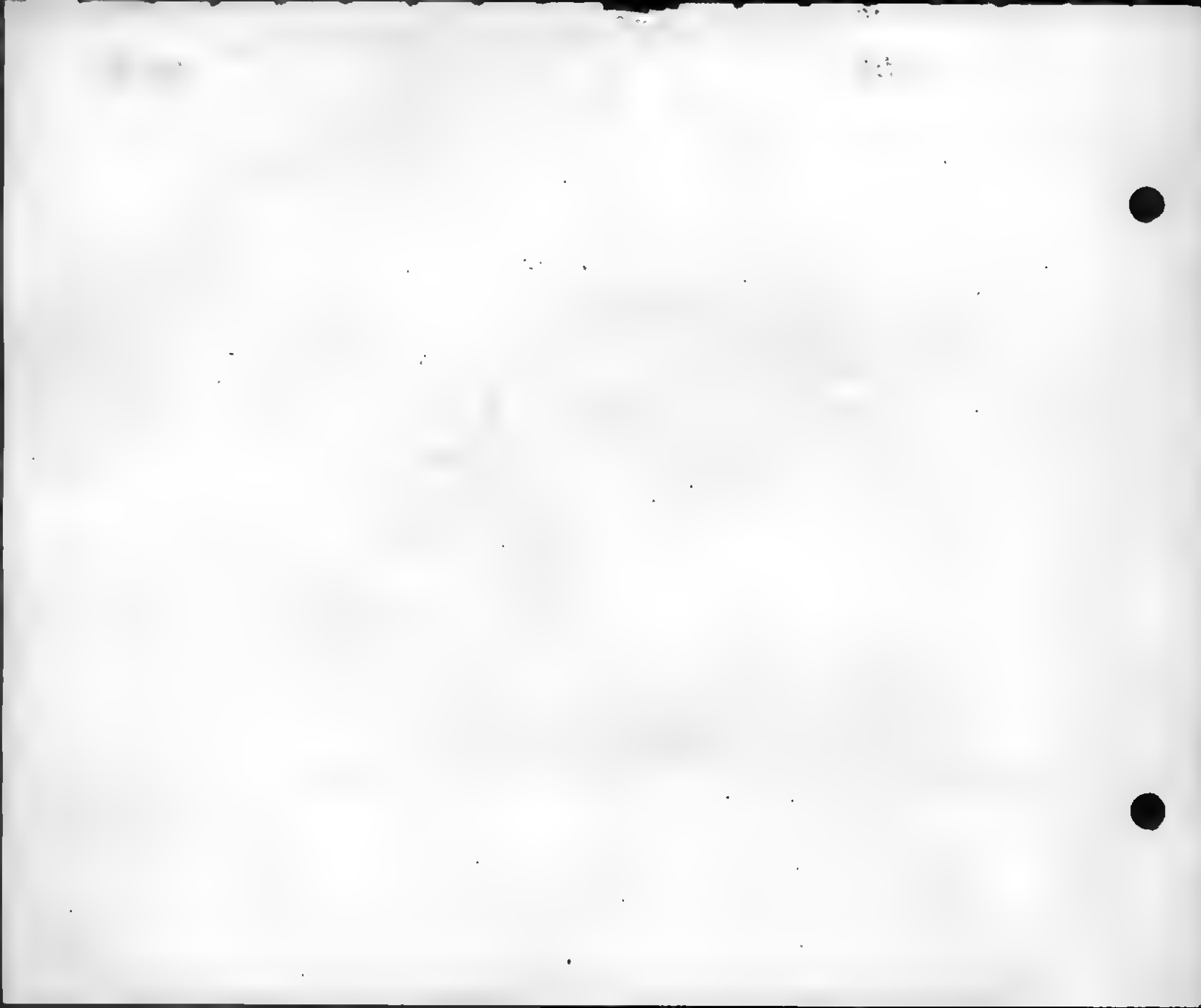
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15074 CERTIFICATE OF DEATH 15075

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Asbury Hall road.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rugby HALL Arnold D.</u>	
c. LENGTH OF STAY IN 1b <u>Asbury Hall road.</u>		d. STREET ADDRESS <u>CAVALIER Drive.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cavalier Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen Jane GIBBONS</u>		4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 25, 1920</u>
9. AGE (in years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Herbert Ogier</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ballard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>EDWARD E. GIBBONS JR. #2</u>	
17. INFORMANT <u>EDWARD E. GIBBONS JR. #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Respiratory Center Failure</u>			
DUE TO (b) <u>Malignant Brain Tumor.</u>			
DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u> </u> to <u>1966</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>10-12-66</u> , and that death occurred at <u>7:39</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u>		22b. DATE SIGNED <u>11-3-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>		22d. ADDRESS <u>P.O. Box 73 Severna Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-5-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. MARGARETS</u>		23d. LOCATION (City, town or county) (State) <u>St. MARGARETS MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Byrnes</u>		25a. REC'D BY REGISTRAR <u>NOV 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>Annapolis, Md.</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

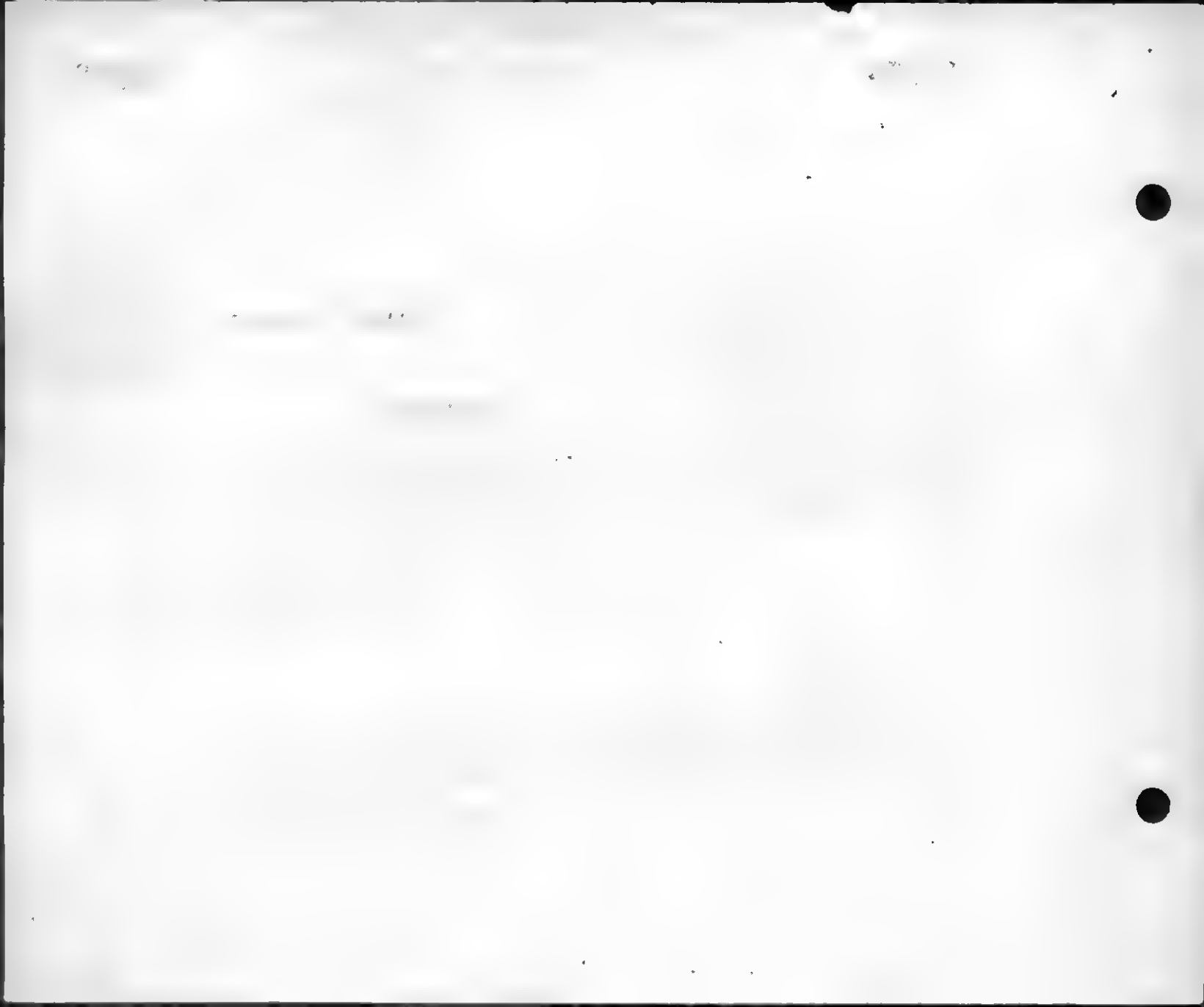
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15075

CERTIFICATE OF DEATH

15076

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY in 1b <u>14 FISK CIRCLE ANNAPOLIS MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>		d. STREET ADDRESS <u>VAN BURAN & Bay Ridge</u>	
3. NAME OF DECEASED (Type or print) First <u>MORRIS</u> Middle <u>GOLDMAN</u> Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month <u>NOV</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1875</u> <u>12-1-1900</u>
9. AGE (In years last birthday) <u>90</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>HOUSE PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SIMON GOLDMAN</u>		14. MOTHER'S MAIDEN NAME <u>CLARA LEMANS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>060-28-7986</u>	
17. INFORMANT <u>ANNAPOLIS NURSING HOME</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the rectum</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a) sloting the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/14</u> , 19 <u>66</u> , to <u>11/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> , 19 <u>66</u> , and that death occurred at <u>9:45 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Richard I. Hochman</u> M.D.		22b. DATE SIGNED <u>11/18/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>		22d. ADDRESS <u>59 Franklin St. Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/20/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WELLWOOD</u>		23d. LOCATION (City or Town) (County) (State) <u>Farmingdale, Long Island, N.Y.</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 22 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or reinterment, and in any event within 72 hours after death.

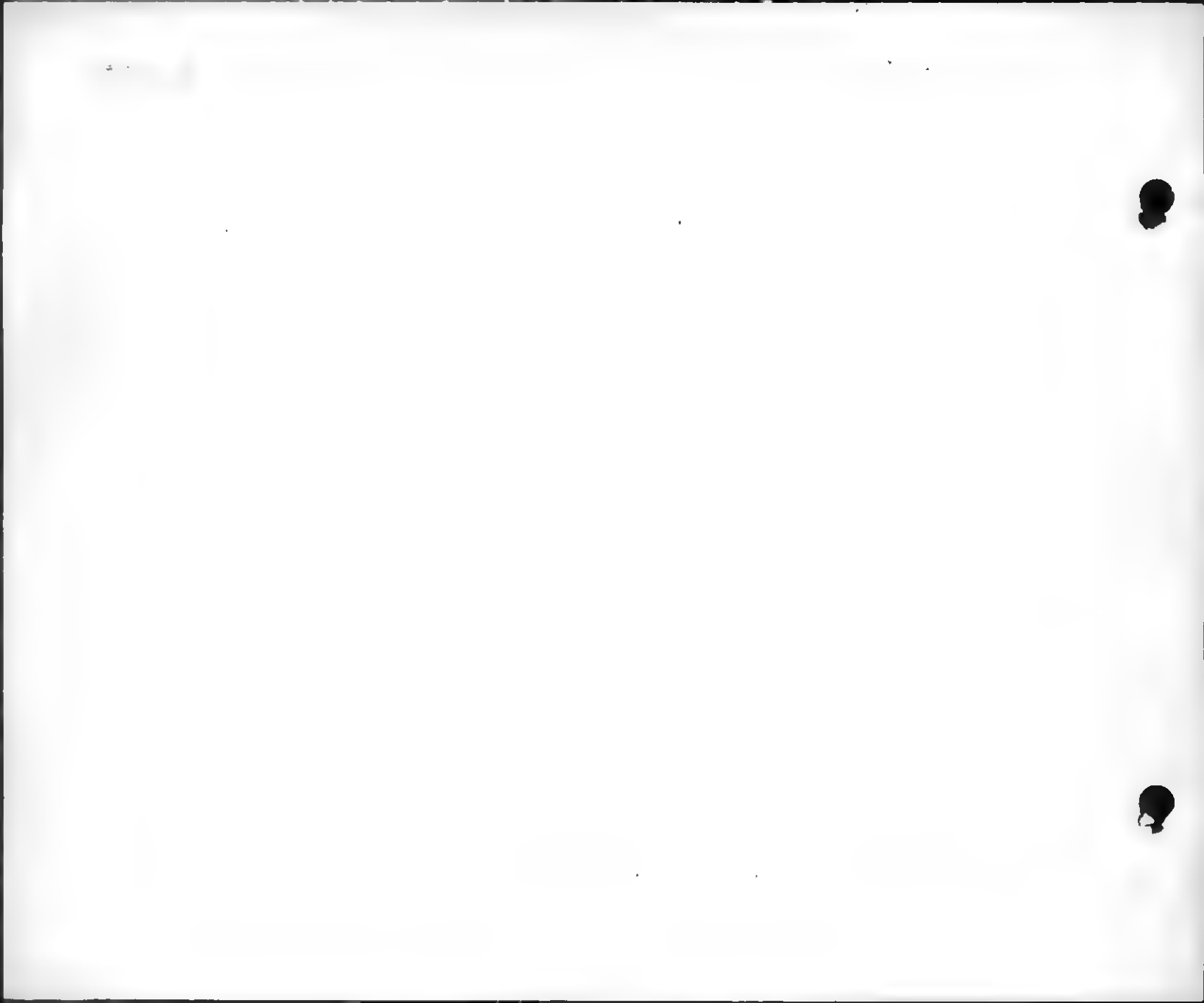
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15076

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15077

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b ANNAPOLIS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNAPOLIS GENERAL HOSPITAL				e. STREET ADDRESS 1 Murray Avenue - Apt. #3			
3. NAME OF DECEASED (Type or print) First Middle Last GLORIA Lorraine Goudreau				4 DATE OF DEATH Month Day Year 11 29 1966			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-1-66	9 AGE (In years lost birthday) yrs 8 weeks 8 days 8 hours 8 min	10a. USUAL OCCUPATION (Give kind of work done during most of working life, or even if retired) None		
10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward G. Goudreau, Jr.				14. MOTHER'S MAIDEN NAME Patricia Anne Hall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO ---		17. INFORMANT Patricia Anne Goudreau Address #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 525X Interstitial pneumonitis (SDIT) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month Day Year Hour: 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz M.D.				22. DATE SIGNED 11-29-66			
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		12-2-66		Hillcrest		Annapolis, MD	
24. FUNERAL DIRECTOR John M. Lytle & Sons				ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DEC 5 1966	
				25b. REGISTRAR'S SIGNATURE Werner U. Spitz			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then use remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1

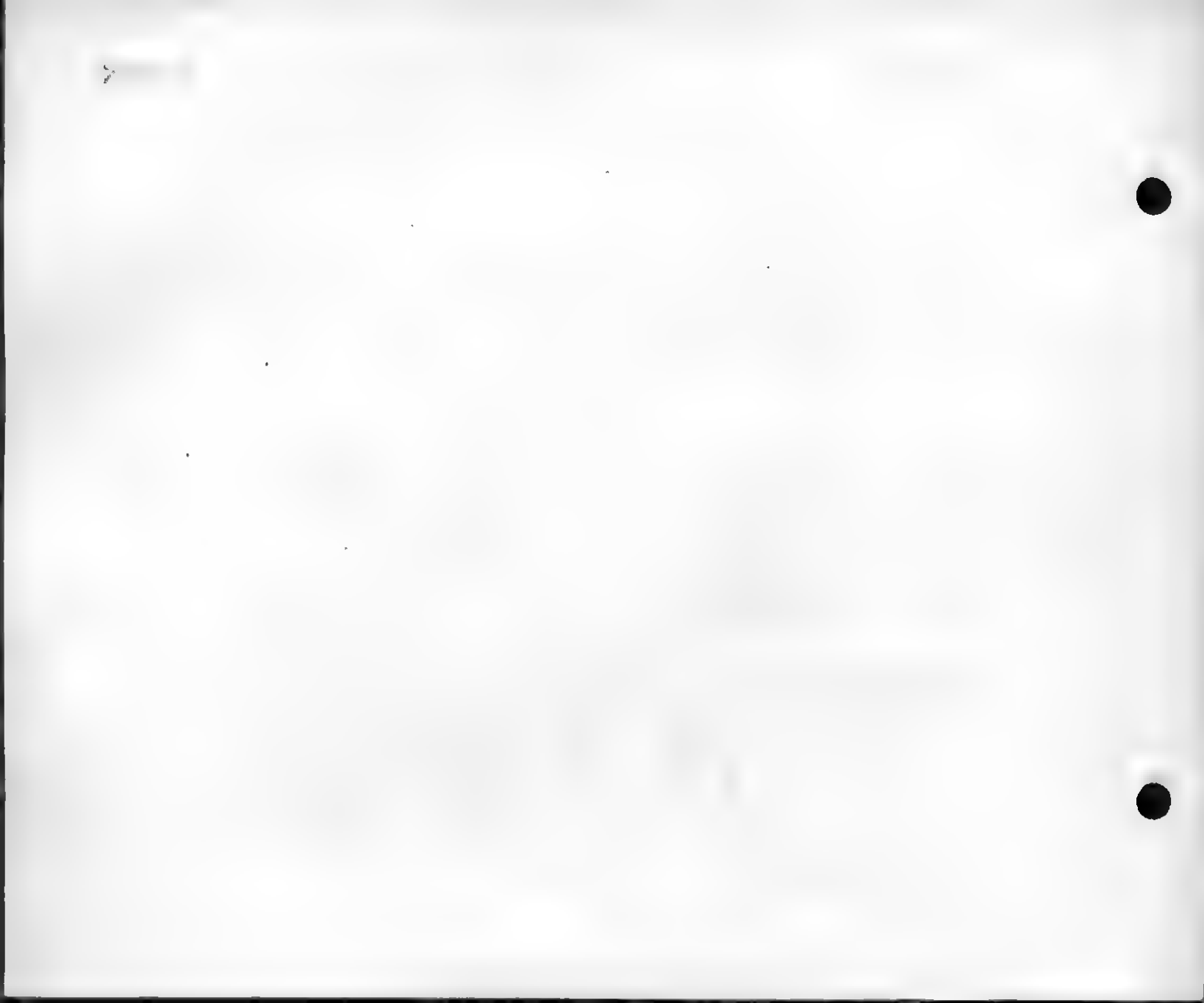
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15077

CERTIFICATE OF DEATH

15078

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>4 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis Nursing & Conv. Center</u> <u>Bay Ridge Ave.</u>		d. STREET ADDRESS <u>Rt. #3 Box 521</u>	
3. NAME OF DECEASED (Type or print) <u>Norcen A. Haas</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1920</u>
9. AGE (In years last birthday) <u>46</u> yrs		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Char lady</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Garden</u>		14. MOTHER'S MAIDEN NAME <u>Annie Weser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Althea Jackson</u>		<u>3108 Winter Green Ave</u> <u>Wash, D.C. 20028</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mental trauma secondary to basal</u> <u>1539</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) <u>to liver, lung, brain, peritoneal cavity.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> to <u>Nov.</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-25</u> , 19 <u>66</u> , and that death occurred at <u>4:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. F. Verkouw</u>		22b. DATE SIGNED <u>11-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Verkouw</u>		22d. ADDRESS <u>1407 Forest Dr. Annapolis, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-29-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fair Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County Md</u>
24. FUNERAL DIRECTOR <u>Charles P. Falar</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 29 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or reinterment in any event, within 72 hours after death.

1.

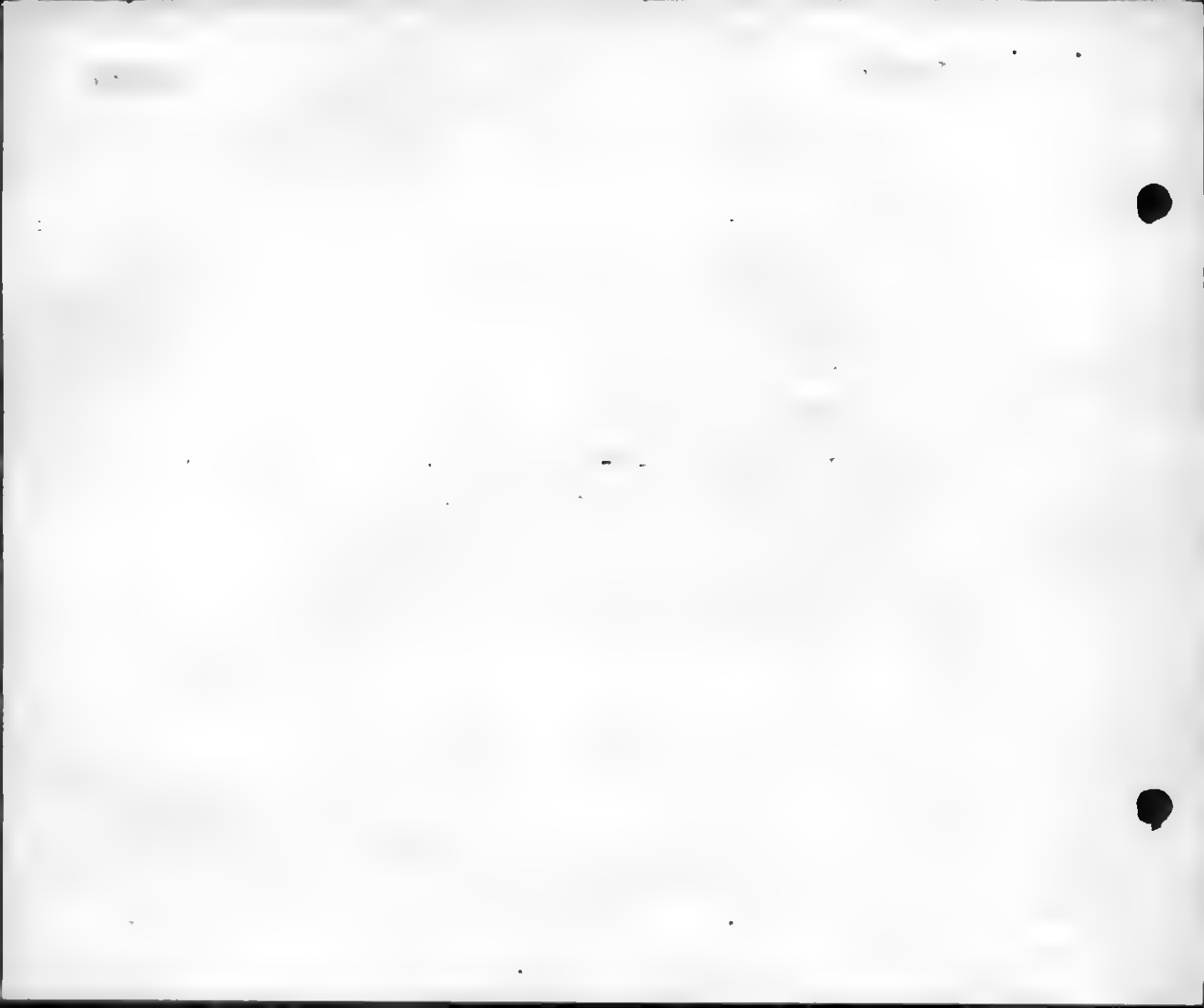
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15078

CERTIFICATE OF DEATH

15079

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE		c. LENGTH OF STAY IN 1b 1 Hr, 45 Mins		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				d. STREET ADDRESS 7 SOUTH MEADOW DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last MARGARET CATHERINE HALL				4 DATE OF DEATH Month Day Year NOVEMBER 17 19 66			
5 SEX FEMALE	6 COLOR OR RACE CAU	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1923		9 AGE (In years last birthday) 43 yrs	F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Plastic Firm		11. BIRTHPLACE (County & State, or foreign country) Passiac, New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin Burgoyne				14. MOTHER'S MAIDEN NAME Jessie McKay Gallette			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII 1942-44		16. SOCIAL SECURITY NO 139-14-5483		17 INFORMANT Address Arthur P. Hall, 7 S Meadow Dr. Glen Burnie, Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE SIX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 3 (this hospital) attended the deceased from 1pm 17 Nov, 1966 , to 2:45pm 17, Nov 66 , that (i) (we) last saw the deceased alive on 17 Nov 1966 , and that death occurred at 2:45pm , from causes and on the date stated above.							
22a. SIGNATURE Joseph C. DiMarco CPT MC M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 17 Nov 66	
22c. PHYSICIAN'S NAME (Type) JOSEPH C. DIMARCO, CPT, MC				22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 21 Nov. 66		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.				25a. REC'D BY REGISTRAR DATE NOV 22 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

(C)

(I)

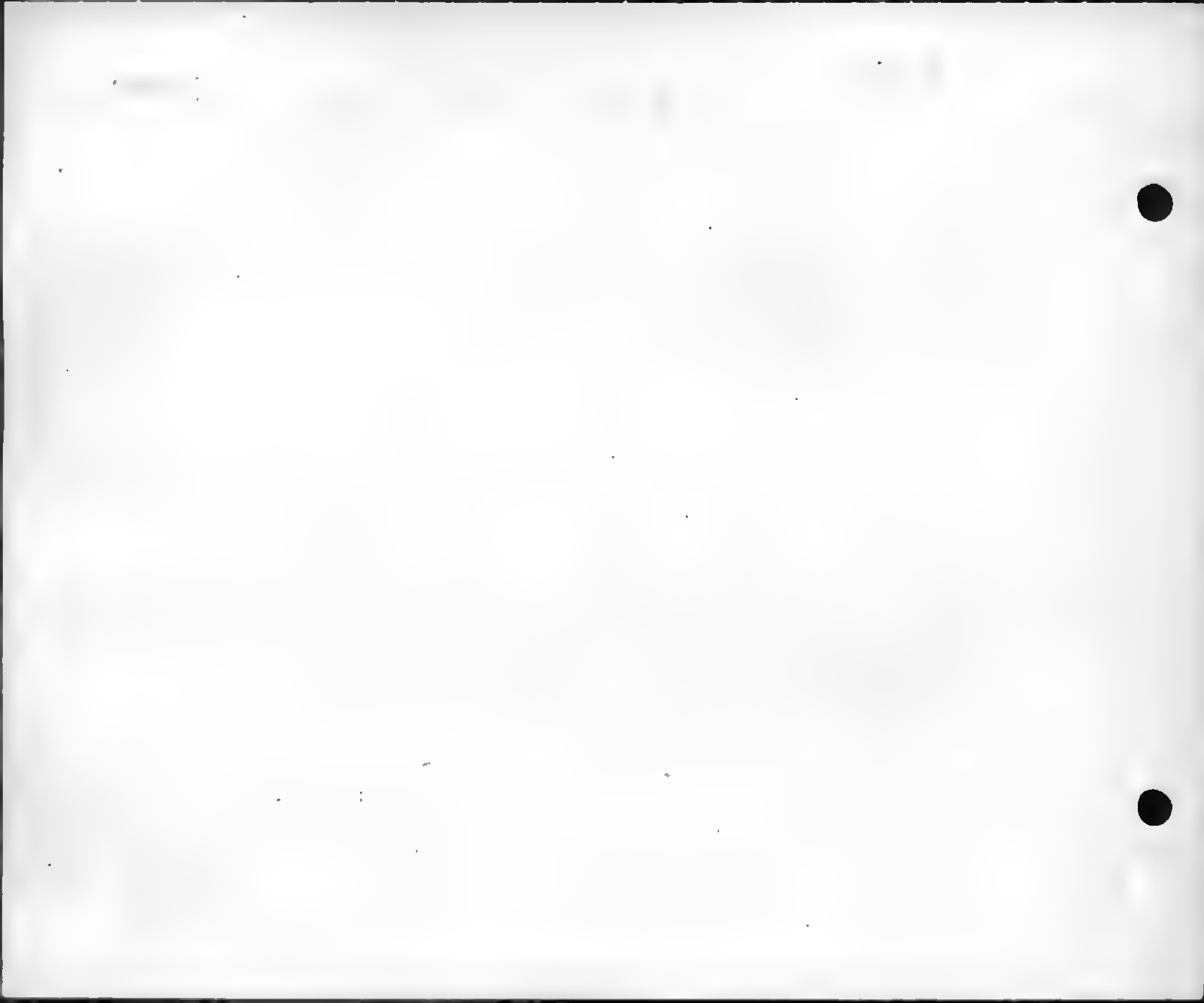
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15079

CERTIFICATE OF DEATH

15084

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Calvert ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dares Beach 64	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Prince Fredrick	
3. NAME OF DECEASED (Type or print) First William Middle Timothy Last HALSTEAD		4. DATE OF DEATH Month November Day 8 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 8, 1966
9. AGE (In years lost birthday) yrs 30		10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Turner Halstead		14. MOTHER'S MAIDEN NAME Joyce A. Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO —	
17. INFORMANT William T. Halstead, Prince Fredrick		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hydrocephalus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumoburitis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/8 , 19 66 , to 11/8 , 19 66 , that (I) (two) last saw the deceased alive on 11/8 , 19 66 , and that death occurred at 5:01 A.M. from causes and on the date stated above.			
22a. SIGNATURE Robert A. Riley, Jr. M.D.		22b. DATE SIGNED 11/11/66	
22c. PHYSICIAN'S NAME (Type) ROBERT A. RILEY, JR.		22d. ADDRESS 95 CATHEDRAL ST. ANNAPOLIS, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 14, 1966	23c. NAME OF CEMETERY OR CREMATORY Our Lady Star of the Sea Cemetery	23d. LOCATION (City or Town) (County) (State) 5010 Monro Calvert, Md.
24. FUNERAL DIRECTOR A. A. Nordmeyer - San Port Republic, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 15 1966	

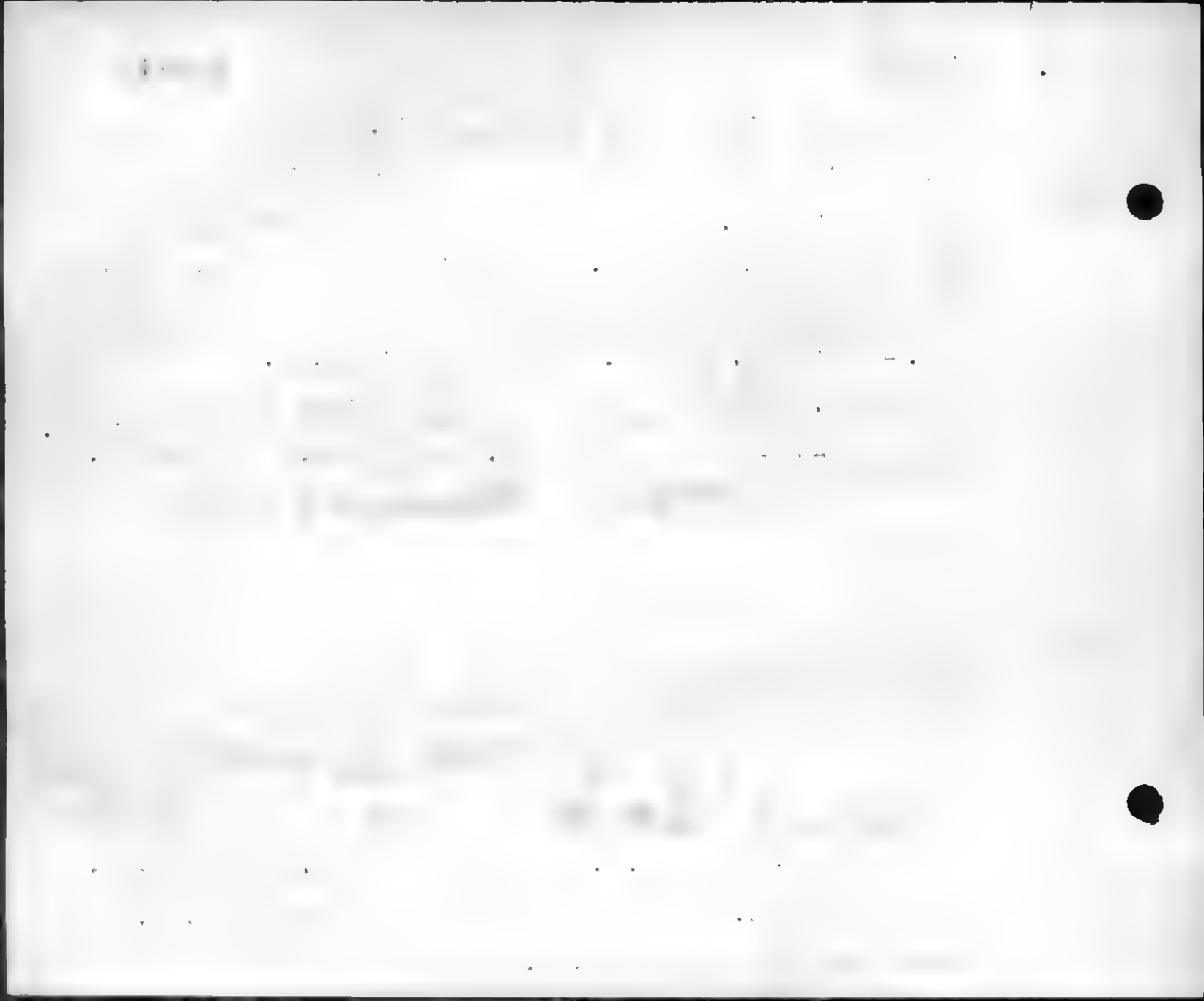


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15080 **CERTIFICATE OF DEATH** **15081**

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>707 Crain Highway N.</u>				d. STREET ADDRESS <u>707 Crain Highway N.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>S.</u> Last <u>Harding</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1966</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 May 1903</u>		9. AGE (In years last birthday) <u>63 yrs.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prop. - Service Sta.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George I. Harding</u>				14. MOTHER'S MAIDEN NAME <u>Lillie May Ruby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mildred Praley, Ritchie Hwy.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Adenocarcinoma of the Lung</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>12 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>66</u> , to <u>today</u> , that (I) (we) last saw the deceased alive on <u>11/14</u> , 19 <u>66</u> , and that death occurred at <u>11:20</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Wayne B. Tate</u>				22b. DATE SIGNED <u>11/14/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Wayne B. Tate, M. D.</u>	
22d. ADDRESS <u>108 Central Ave., Glen Burnie, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>15 Nov. 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15081

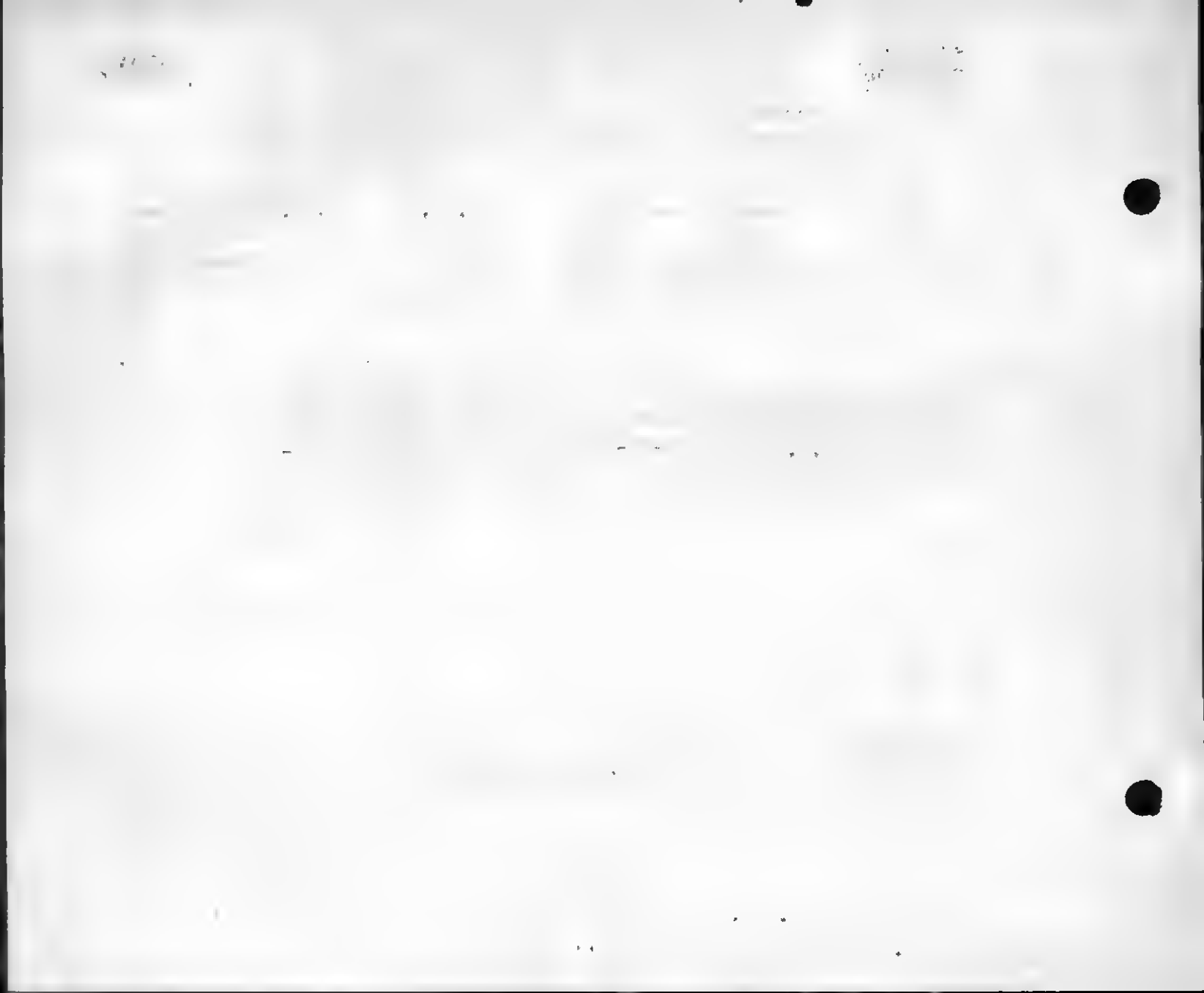
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15082

1. PLACE OF DEATH e. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS Rt. 6, Box 249, Mt. Pleasant Beach e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gerald Middle Gordon Last Hartley			4. DATE DEATH November 24 1966				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1919	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 4 Days 10 Hours 15 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi		11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Maryland			
13. FATHER'S NAME William McKinney Hartley			14. MOTHER'S MAIDEN NAME Irene Grindle				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. II 217-10-5943		17. INFORMANT Rita Matilda Hartley - same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Coronary arteriosclerotic heart disease DUE TO 5 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)					INTERVAL BETWEEN ONSET AND DEATH 1 hour		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 7/22, 1936 , to 11/24, 1966 , that (I) (we) last saw the deceased alive on 9/30, 1966 , and that death occurred at 4 A M, from the causes and on the date stated above.							
22a. SIGNATURE R.M. McLaughlin			22b. DATE SIGNED 11/25/66				
22c. PHYSICIAN'S NAME (Type) R.M. McLaughlin			22d. ADDRESS Pasadena, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 28, 1966	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town or county) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR George J. Gonce- 4001 Ritchie Hgwy., Baltimore			25a. REC'D BY REGISTRAR NOV 29 1966	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15082

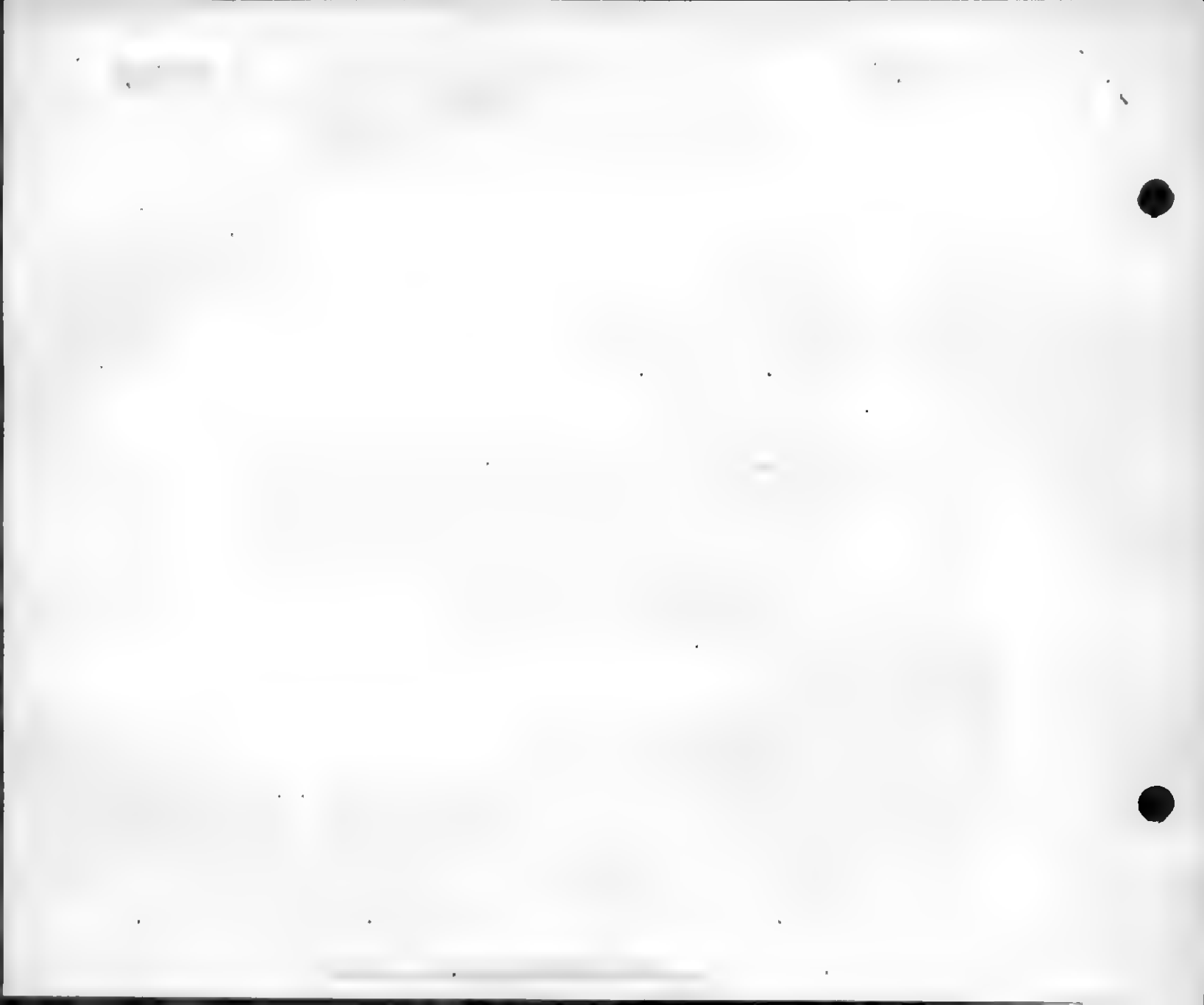
CERTIFICATE OF DEATH

15083

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB 4 weeks		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. STREET ADDRESS Box 34, Rt. 5 (Mag. Bridge Rd.)				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Henry		4. DATE OF DEATH Month November		Day 16		Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1895	9. AGE (In years last birthday) 71 yrs	10. IF UNDER 1 YEAR Months 16		11. IF UNDER 24 HRS Days 19		12. IF UNDER 24 HRS Hours 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Chev. Plant		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Israel Houston Hartsell				14. MOTHER'S MAIDEN NAME Mandy Malinda Hartsell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 243-01-8535		17. INFORMANT Address Mrs. Dollie A. Hartsell (Wife) Same as #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) coronary artery disease DUE TO (c) arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH few hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) emphysema, pulmonary								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 15, 1966 , to Nov. 16, 1966 , that (I) (we) last saw the deceased alive on Nov. 15, 1966 and that death occurred at 5:40 A.M. from causes and on the date stated above.									
22a. SIGNATURE Ray M. Smith		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 16 Nov. 1966	
22c. PHYSICIAN'S NAME (Type) RAY M. SMITH MD		22d. ADDRESS Sierra Park Road							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 19, 1966		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.			
24. FUNERAL DIRECTOR Richard W. Singleton				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR NOV 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

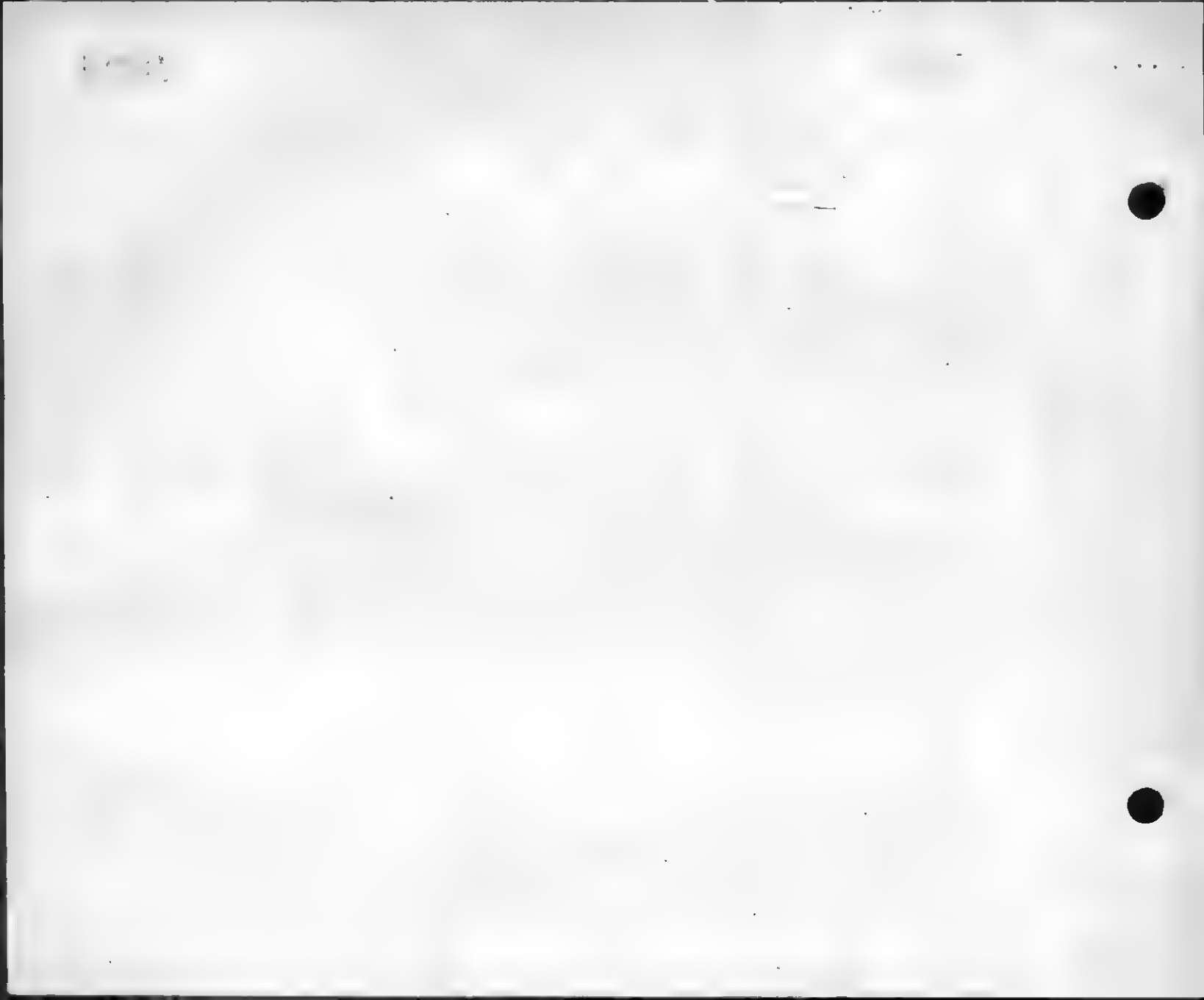
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15083 CERTIFICATE OF DEATH 15084

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>1111</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena. (High Point)</u> d. STREET ADDRESS <u>248 Riverside Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Thomas Heaphy</u> First Middle Last 4. DATE OF DEATH <u>November 3</u> 19 <u>66</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>December 29, 1914</u> 9. AGE (in years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel mgr</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Cat's Paw (mgr)</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Harry Heaphy</u> 14. MOTHER'S MAIDEN NAME <u>Rose Andrews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>212-10-1580</u> 17. INFORMANT <u>MR James O Heaphy (son)</u> Address <u>107 Bonnie View Rd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 11201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>DUE TO</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heaves - 2 years duration</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> , 19 <u>60</u> , to <u>11/3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> , 19 <u>66</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R.M. McLaughlin</u> 22c. PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin, M.D.</u>		22b. DATE SIGNED <u>November 4, 1966</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>3708 Mount Air Rd. Pasadena, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Nov 7, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u> 23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>		24. FUNERAL DIRECTOR <u>Richard V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u> 25a. REC'D BY REGISTRAR <u>NOV 9</u> 19 <u>66</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J.</u>	



3 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and Page 4 event within 72 hours after death.

VR A15ME (5)
6M 1/66

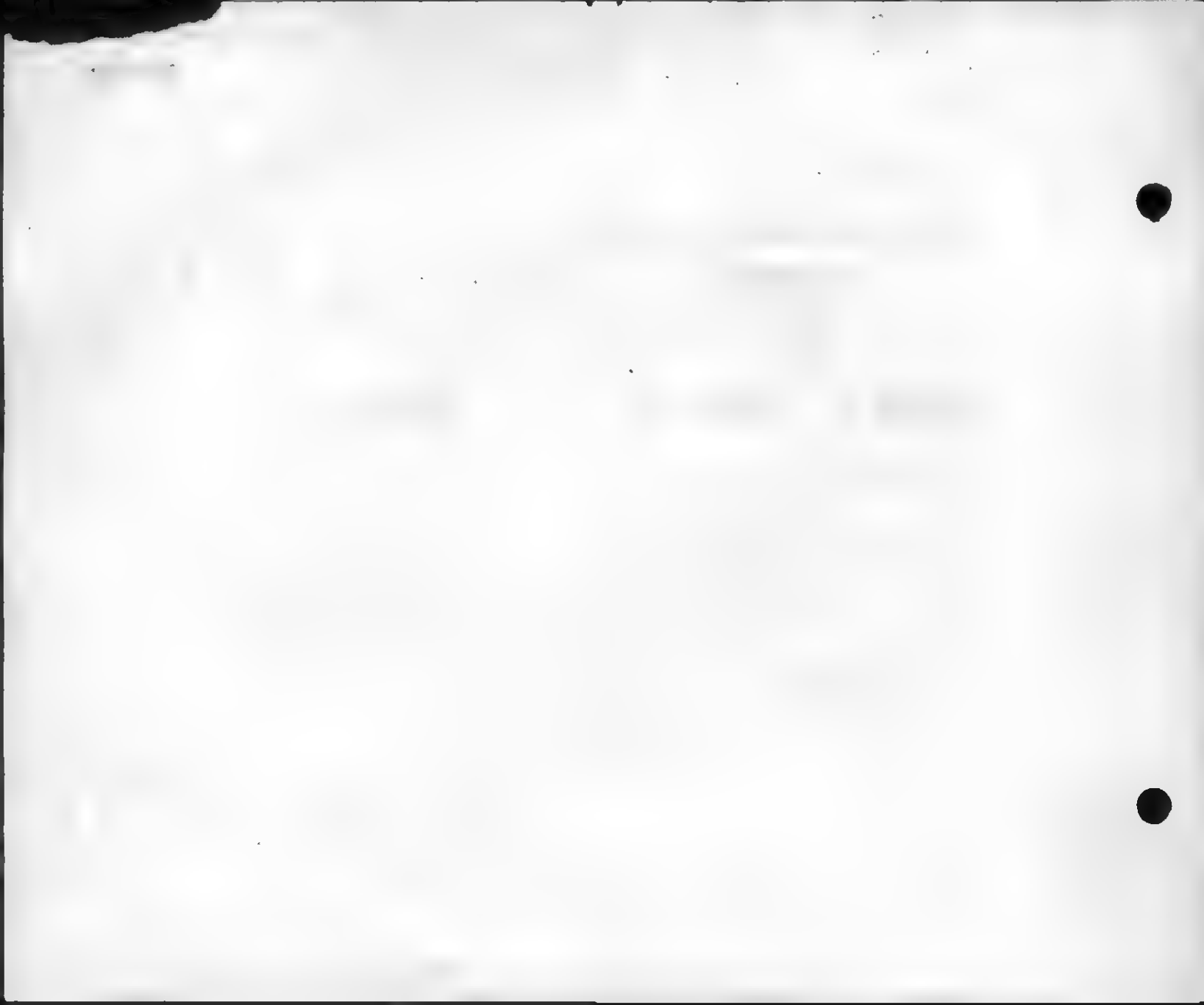
<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> </div> <div> <p>15084</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> <p>15085</p> </div> </div>									
1 PLACE OF DEATH a COUNTY <u>AA-Co.</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>AACU</u>				
b CITY OR TOWN (If outside corporate limits write PLRA, and give nearest town) <u>Annapolis-MD.</u>			c LENGTH OF STAY N 1b		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Gambrells-MD</u>				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A - Annie ARUNDIEL - Gen.</u>					d STREET ADDRESS <u>WAIL Chapel Rd.</u>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>Hebron</u> Last <u>Hebron</u>					4 DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1966</u>				
5 SEX <u>M</u>		6 COLOR OR RACE <u>N</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>4/28/10</u>		9 AGE (In years last birthday) <u>56</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck DRIVER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (State or foreign country) <u>MD</u>			12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13 FATHER'S NAME <u>Robert Hebron</u>					14 MOTHER'S MAIDEN NAME <u>Hazel Banks</u>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW2</u>				16 SOCIAL SECURITY NO <u>-</u>		17 INFORMANT <u>Hortense Baynes Sister</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerosis generalized</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month Day Year Hour a.m. _____ p.m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21 I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u>				22. DATE SIGNED Address (Street, city, town, or county) <u>11.12.66</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <u>11-17-66</u>		23c NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Arlington Virginia</u>			23d LOCATION (City or town) (County) (State)		
24 FUNERAL DIRECTOR <u>W.S. WASHINGTON & SONS</u> <u>4925 DEANE AVE. N.E. - D.C.</u>						25 DATED BY REGISTRAR <u>NOV 21 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15085		MARYLAND STATE DEPARTMENT OF HEALTH		Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
Annapolis Nursing Home		Certificate of Death		15086	
1 PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis Nursing Home</u>		d. STREET ADDRESS <u>RT #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Catherine E. Higdon</u>		4 DATE OF DEATH <u>Nov 4 1966</u>		Month Day Year	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1890 MAY 16 - 1889</u>	9 AGE (In years last birthday) <u>76</u> yrs	10 UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SERVICE</u>		11 BIRTHPLACE (County & State or foreign country) <u>WOODWARD MASS</u>	
13 FATHER'S NAME <u>TERENCE MAGUIRE</u>		14 MOTHER'S MAIDEN NAME <u>BRIDGITT</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>-</u>		17 INFORMANT <u>THOMAS J. HIGDON</u> Address <u>RT 2 BOX 21388 EDGEWATER MD.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Compensated heart failure</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myocardial infarction (acute)</u> DUE TO (c) <u>Ray</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized atherosclerosis</u>					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21 I certify that (I) (this hospital) attended the deceased from <u>11/3/66</u> , 19 <u>66</u> , to <u>11/4/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/3/66</u> , 19 <u>66</u> , and that death occurred at <u>8:20 A.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Gerard Churel</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/5/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GERARD CHUREL</u>		22d. ADDRESS <u>121 Calhoun Pl, Annapolis</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-8-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT. CEM.</u>	
23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON VA.</u>					
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR'S SONS</u>		ADDRESS <u>ANNAPOILIS MD</u>		25a. REC'D BY REGISTRAR <u>NOV 10 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

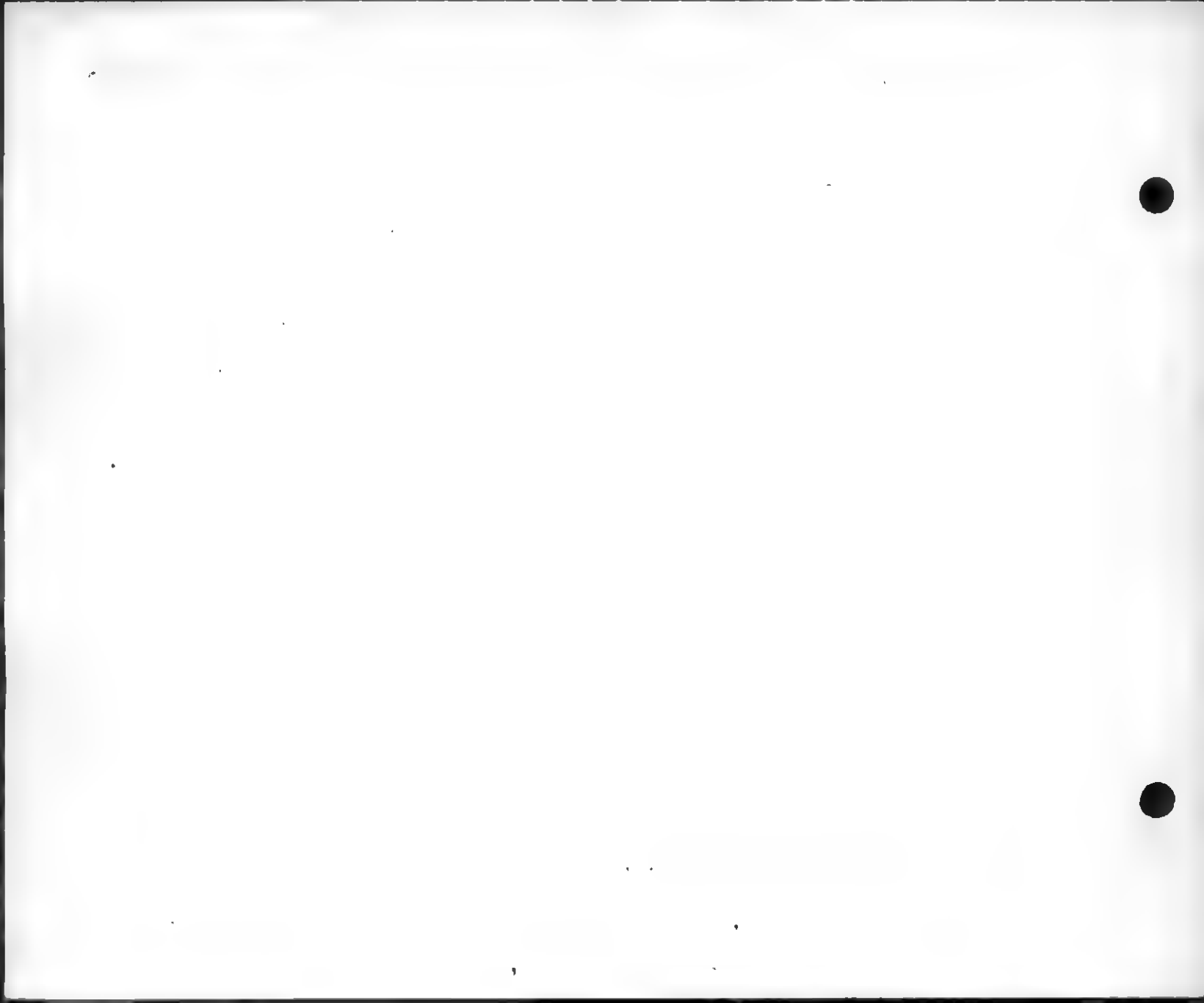
15086

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15087

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Anne Arundel			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c LENGTH OF STAY IN 1b DOA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General				d STREET ADDRESS Rt. 9 Box 230		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Mabel Middle H. Last Holland				4 DATE OF DEATH Month 11 Day 22 Year 19 66			
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 16 Nov. 1884	9 AGE (In years last birthday) yrs 82	10 IF UNDER 1 YEAR Months 11 Days 22		11 IF UNDER 24 HRS Hours 19 Min 66
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (State or foreign country) East New Market, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Samuel Higgins				14 MOTHER'S MAIDEN NAME Mary E. Wright			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO		17 INFORMANT Mrs. Jane Bready, Severna Park, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> partial	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)				22. DATE SIGNED 11/22/66	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 25 Nov. 66		23c NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.				25a REC'D BY REGISTRAR NOV 28 1966		25b REGISTRAR'S SIGNATURE Charles Judge	



15087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15088

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or reburial, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

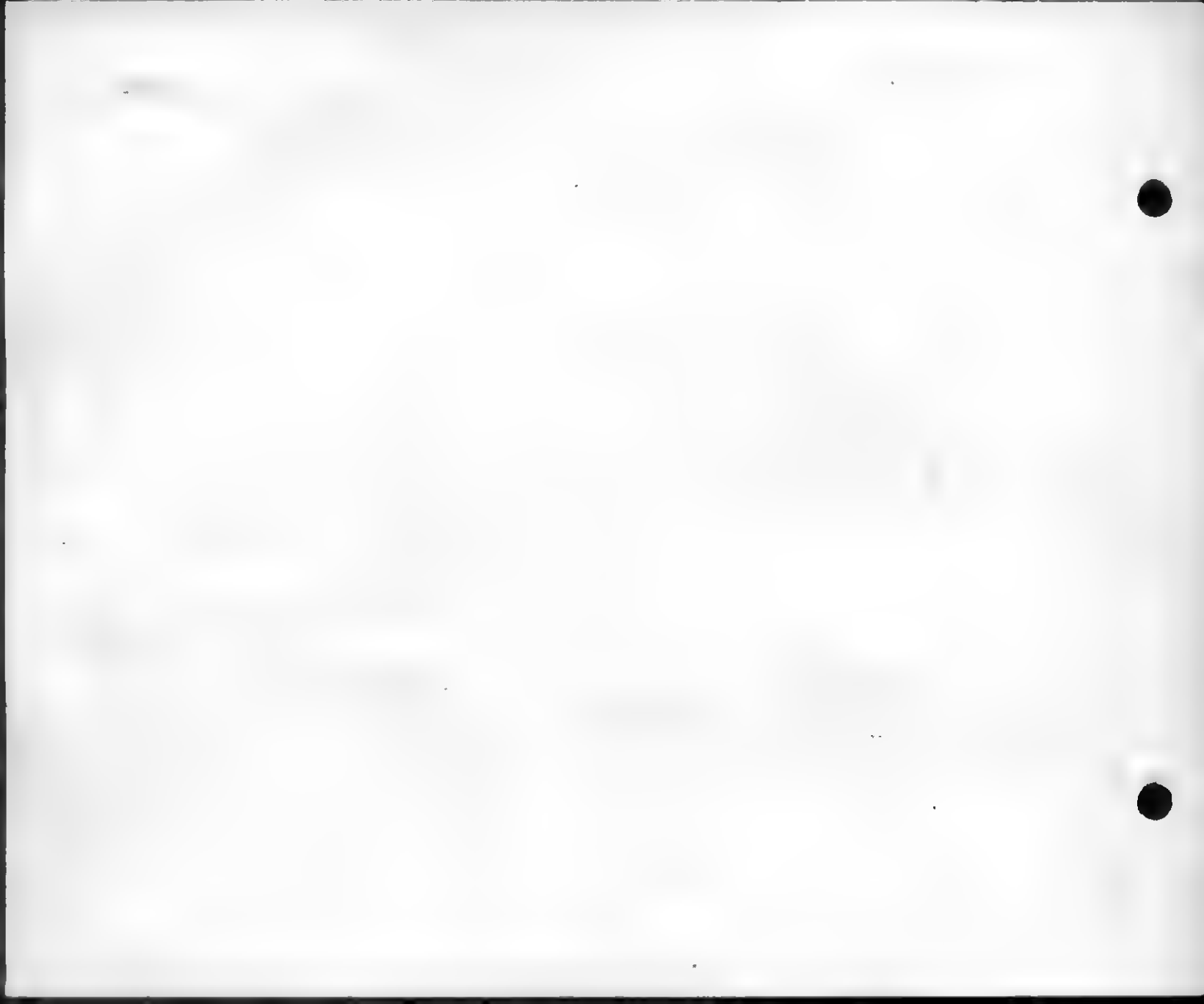
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15088

CERTIFICATE OF DEATH

16534

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c LENGTH OF STAY IN 1b 7 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d STREET ADDRESS Unknown	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) #20327 Alice Hudson		4 DATE OF DEATH Month 11 Day 26 Year 19 66	
5 SEX Female	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/30/97
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months 11 Days 26 Hours 19 Min 66	
10a USUA. OCC. PATION (Give kind of work done during most of working life, even if retired) Unemployed		10b KIND OF BUSINESS OR INDUSTRY -----	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO (c) Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive Heart Failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 11		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/9/ , 19 59 , to 11/26/ , 19 66 , that (I) (we) last saw the deceased alive on 11/28/ 19 66 , and that death occurred at 9:40 M, from causes and on the date stated above.			
22a. SIGNATURE Hildagard Heard Reissman M.D.		22b. DATE SIGNED 11/28/66	
22c. PHYSICIAN'S NAME (Type) Hildagard Heard Reissman		22d. ADDRESS Crownsville State Hospital, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12/20/66	
23c. NAME OF CEMETERY OR CREMATORY UNIVERSITY		23d. LOCATION (City or town) (County) (State) BALTIMORE	
24 FUNERAL DIRECTOR William Reese II 108 W. Washington St.		25a REC'D BY REGISTRAR DEC 22 1966	
25b. REGISTRAR'S SIGNATURE [Signature]			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15089

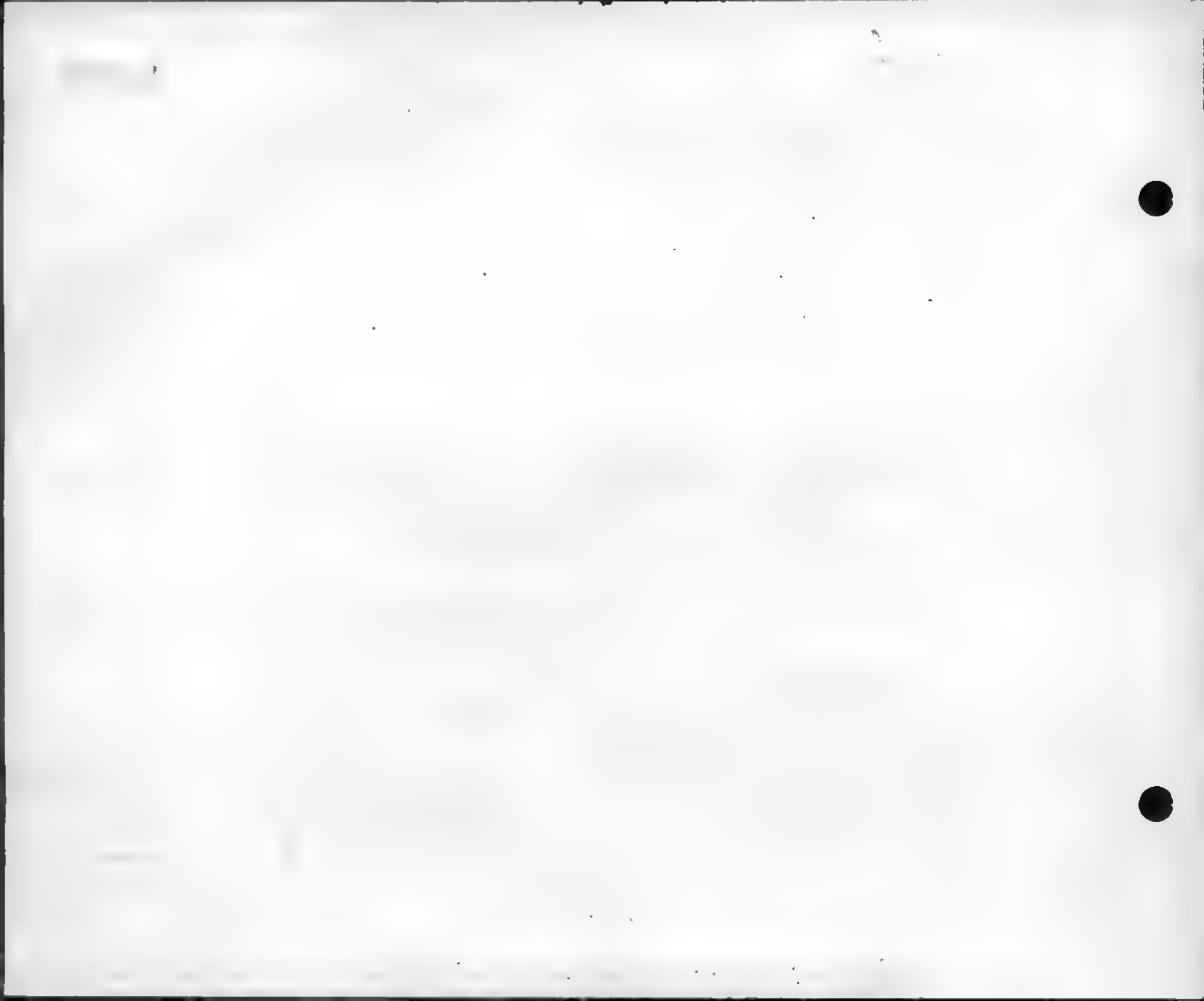
CERTIFICATE OF DEATH

15089

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12 CHESTON AVE		d. STREET ADDRESS 12 CHESTON AVE.	
3. NAME OF DECEASED (Type or print) VIRGINIA REICH HYDE		4. DATE OF DEATH Month 11 Day 19 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-1911
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHESTER M. REICH		14. MOTHER'S MAIDEN NAME FLORENCE ANGELO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. #2	
17. INFORMANT BENJAMIN J. HYDE		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery sclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 month 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 19 63 , to Nov. , 19 66 , that (I) (we) last saw the deceased alive on Nov. 10 , 19 66 , and that death occurred at 8:15 M, from causes and on the date stated above.			
22a. SIGNATURE John Hedeman		22b. DATE SIGNED 11/22/66	
22c. PHYSICIAN'S NAME (Type) John Hedeman		22d. ADDRESS Forest Drive Annapolis Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-22-66	23c. NAME OF CEMETERY OR CREMATORY CEDAR Bluff	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.
24. FUNERAL DIRECTOR John M. Long & Sons Annapolis Md.		25a. REC'D BY REGISTRAR DATE NOV 23 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



15090

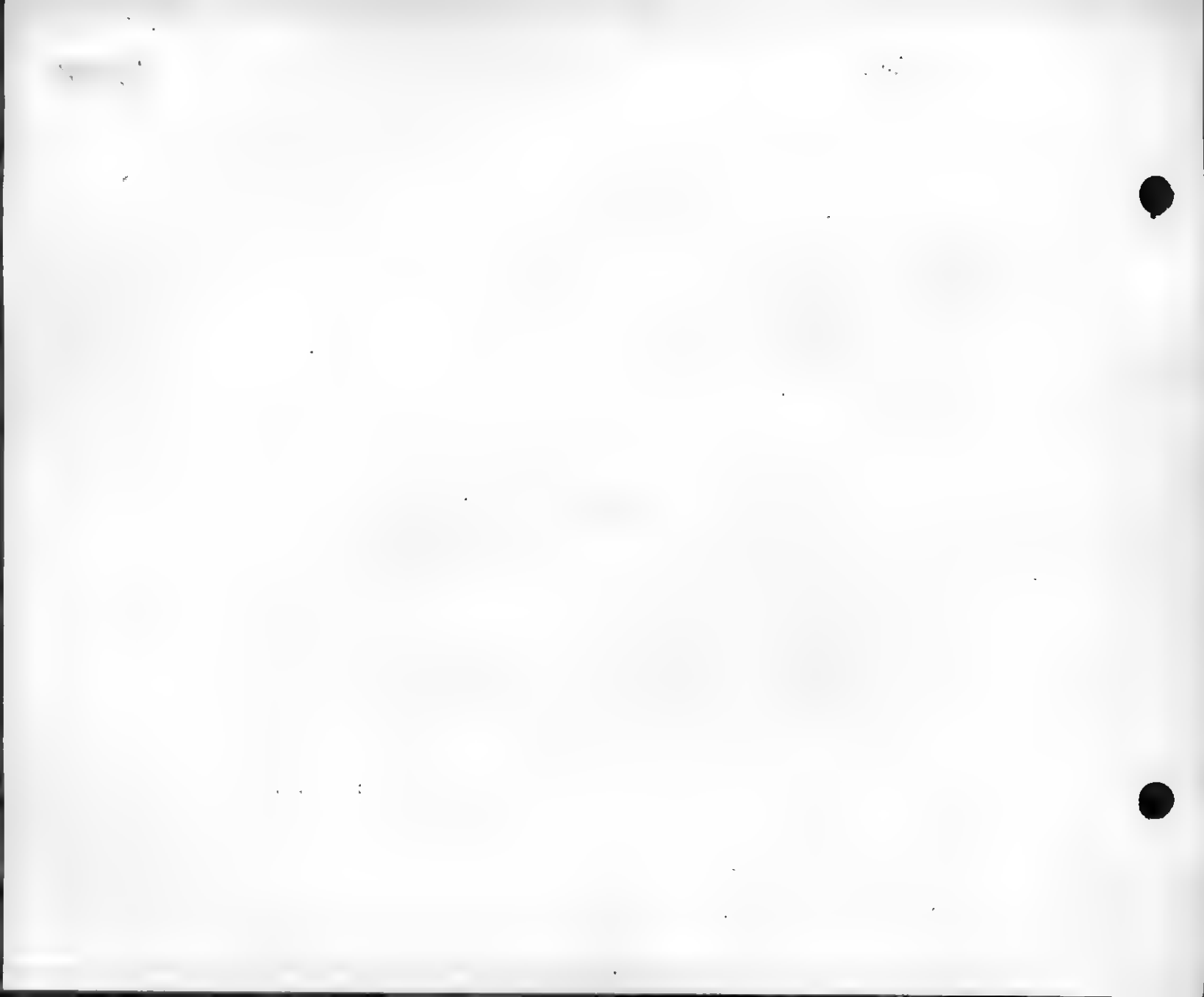
CERTIFICATE OF DEATH

15090

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Annopolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1204 West Street	
3. NAME OF DECEASED (Type or print) Alvin JACKSON		4. DATE OF DEATH Month November Day 13 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 24, 1895
9. AGE (in years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VENETIAN BLINDS WINDOW BLINDS		10b. KIND OF BUSINESS OR INDUSTRY Jewelry	
11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME JAMES M. JACKSON		14. MOTHER'S MAIDEN NAME TOHINE BRADLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW I		16. SOCIAL SECURITY NO PAULINE E JACKSON #2	
17. INFORMANT PAULINE E JACKSON		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Autonochrotic carcinoma of prostate DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 11/11 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 55 , to Nov , 19 66 that (I) (we) last saw the deceased alive on Nov - 13 19 66 , and that death occurred at 1:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE John L Hedeman		22b. DATE SIGNED 11/14/66	
22c. PHYSICIAN'S NAME (Type) JOHN L HEDEMAN		22d. ADDRESS FOREST DR ANNAPOLIS MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-15-66	
23c. NAME OF CEMETERY OR CREMATORY HILLCREST		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR John M. Taylor & Son Annapolis, Md.		25a. REC'D BY REGISTRAR DATE NOV 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (See page 1 for instructions.) Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15091

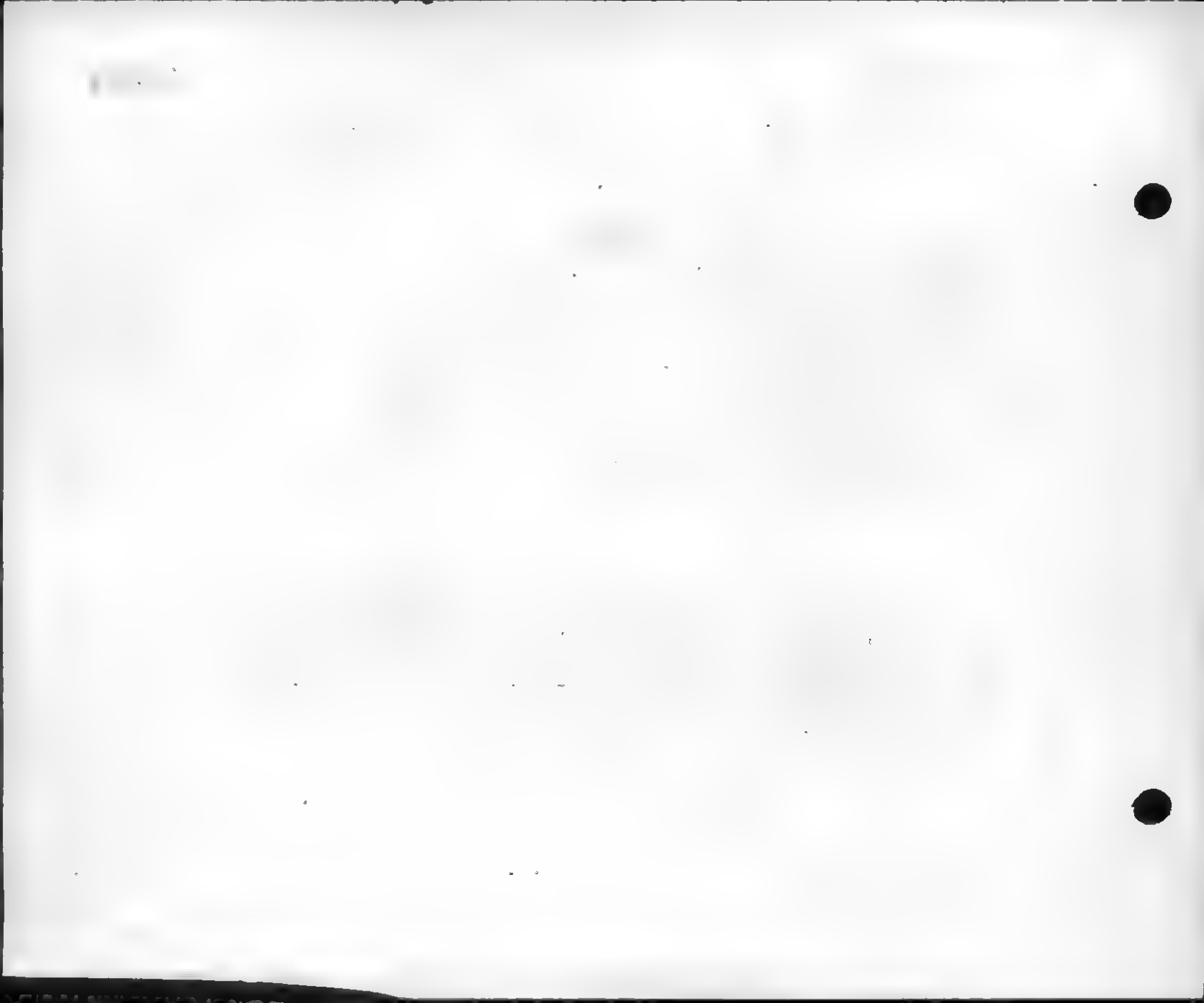
CERTIFICATE OF DEATH

15091

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY in 1b 1 mo. 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		20. 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 220 Beal Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 33459 Edward J. Jackson				4. DATE OF DEATH Month 11 Day 18 Year 1966			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/16/06		9. AGE (In years lost birthday) yrs. 60	10. IF UNDER 1 YEAR Months 11 Days 18 Hours 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Will Jackson				14. MOTHER'S MAIDEN NAME Tamie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-07-8079		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Pancreas with Generalized Metastasis 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Metastasis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, secondary to the above; Carcinoma of the Parotid Gland (left)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year ----- p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/31/1966 , to 11/18/1966 , that (I) (we) last saw the deceased alive on 11/18/1966 , and that death occurred at 2:40 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Lionel McHenry Mapp</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/18/66	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.				22d. ADDRESS Crownsville State Hospital, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-23/66		23c. NAME OF CEMETERY OR CREMATORY MT. Auburn Cmt. Balt.		23d. LOCATION (City or Town) (County) (State) Md.	
24. FUNERAL DIRECTOR E. O. Wilson				25a. REC'D BY REGISTRAR NOV 22 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15092

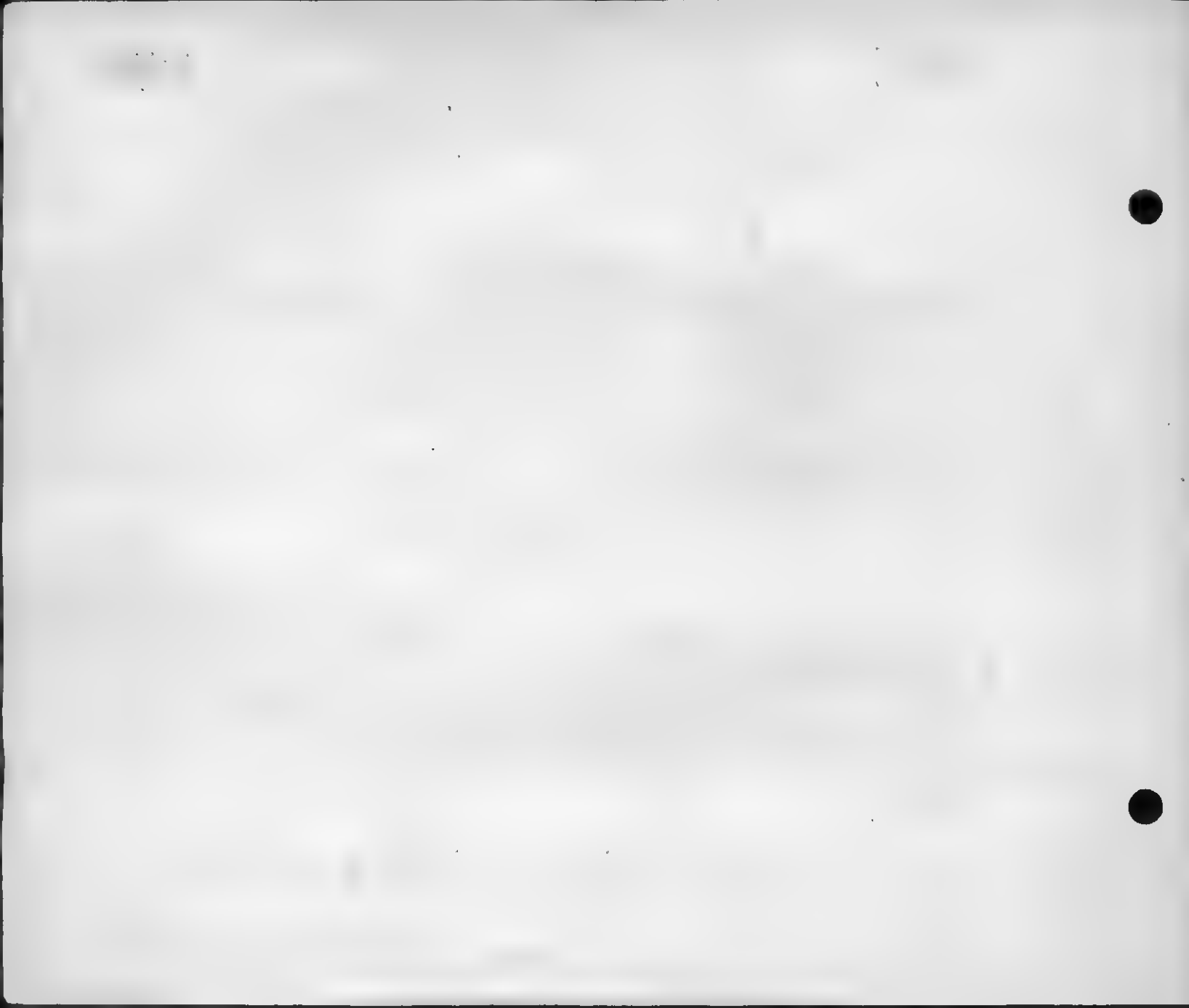
CERTIFICATE OF DEATH

15092

1. PLACE OF DEATH e. COUNTY <u>Ann Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hen Beecher</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Plaza Manor Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Andover</u> d. STREET ADDRESS <u>50 Shaw Street</u>			
3. NAME OF DECEASED (Type or print) <u>Lucy James Jackson</u>		4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1966</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4/25/13</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN (GENERAL UTILITIES)</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Sonoma State Md.</u>			
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Irene D. Williamson</u> Address <u>Box 410 Severna Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary Occlusion</u> DUE TO (b) <u>Pulmonary edema</u> (e), stating the underlying cause last, DUE TO (c) <u>Chronic Emphysema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>unknown</u> <u>unknown</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> 1966 to <u>11/7</u> 1966 that (I) (we) last saw the deceased alive on <u>11/7/66</u> and that death occurred at <u>11 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Hunt</u>		22b. DATE SIGNED _____	22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>NOV 10-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CARPENTERS HILL</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. HICKS III</u>		24b. ADDRESS <u>Annapolis, Md</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15093

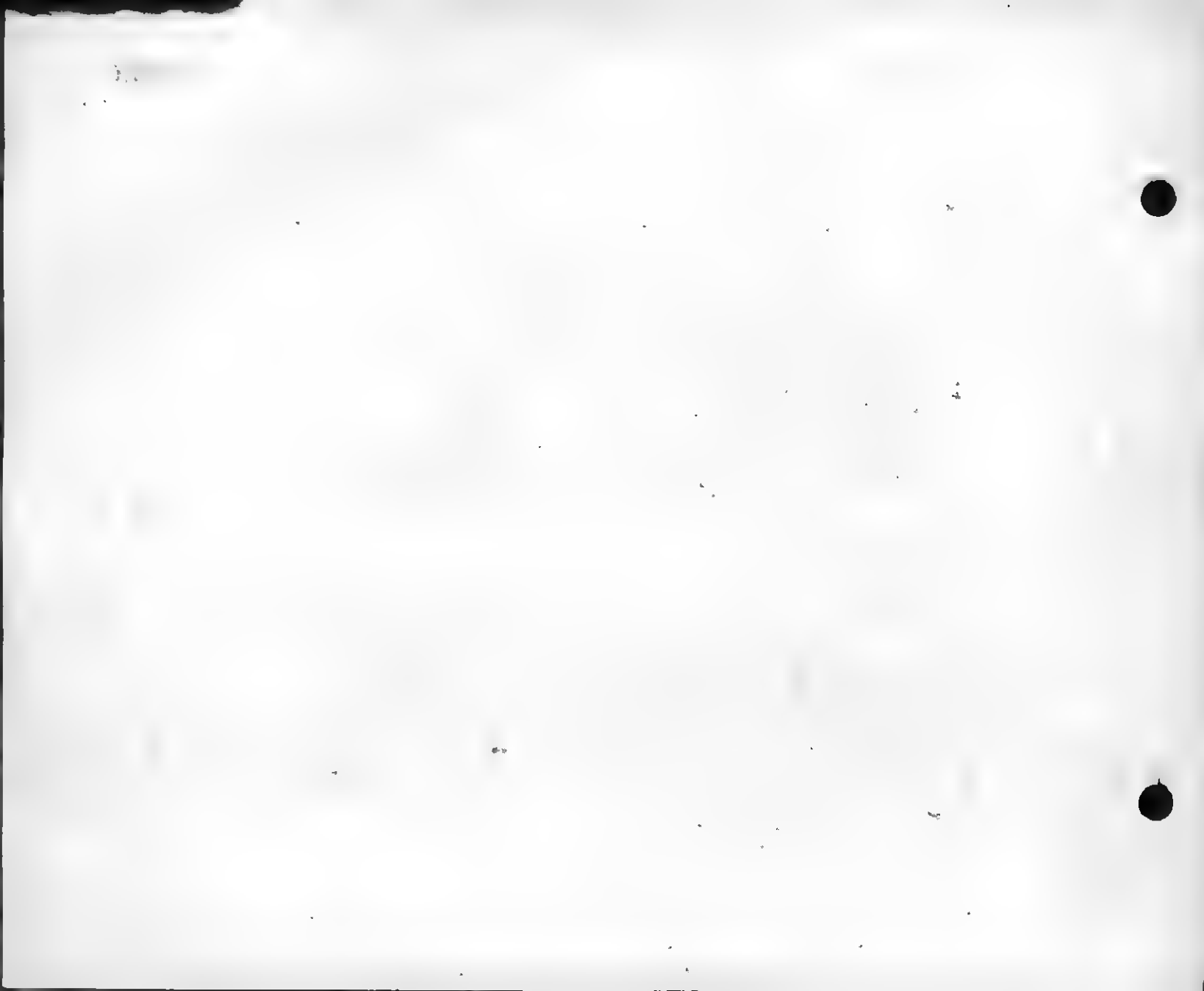
CERTIFICATE OF DEATH

15093

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PROVIDENCE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, MD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>236 PARITAN PLACE</u>		d. STREET ADDRESS <u>58 MD. AVE</u>	
3. NAME OF DECEASED (Type or print) <u>ETHEL</u> First <u>FELDMAYER</u> Middle <u>KING</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-1884</u>
9. AGE (In years (last birthday) yrs) <u>82</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Annapolis MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES G. FELDMAYER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH DAWES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>MRS. JAMES O. OGDEN #1</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic C.V.D.</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 + 3</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1, 1966</u> to <u>11-4, 1966</u> , that (I) (we) last saw the deceased alive on <u>11-1, 1966</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Shipley</u>		22b. DATE SIGNED <u>11-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>F.M. SHIPLEY</u>		22d. ADDRESS <u>121 CATHEDRAL ST. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-7-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>U.S.N. ACADEMY</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>
24. FUNERAL DIRECTOR <u>John M. City</u>		25a. REC'D BY REGISTRAR <u>NOV 10 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15094

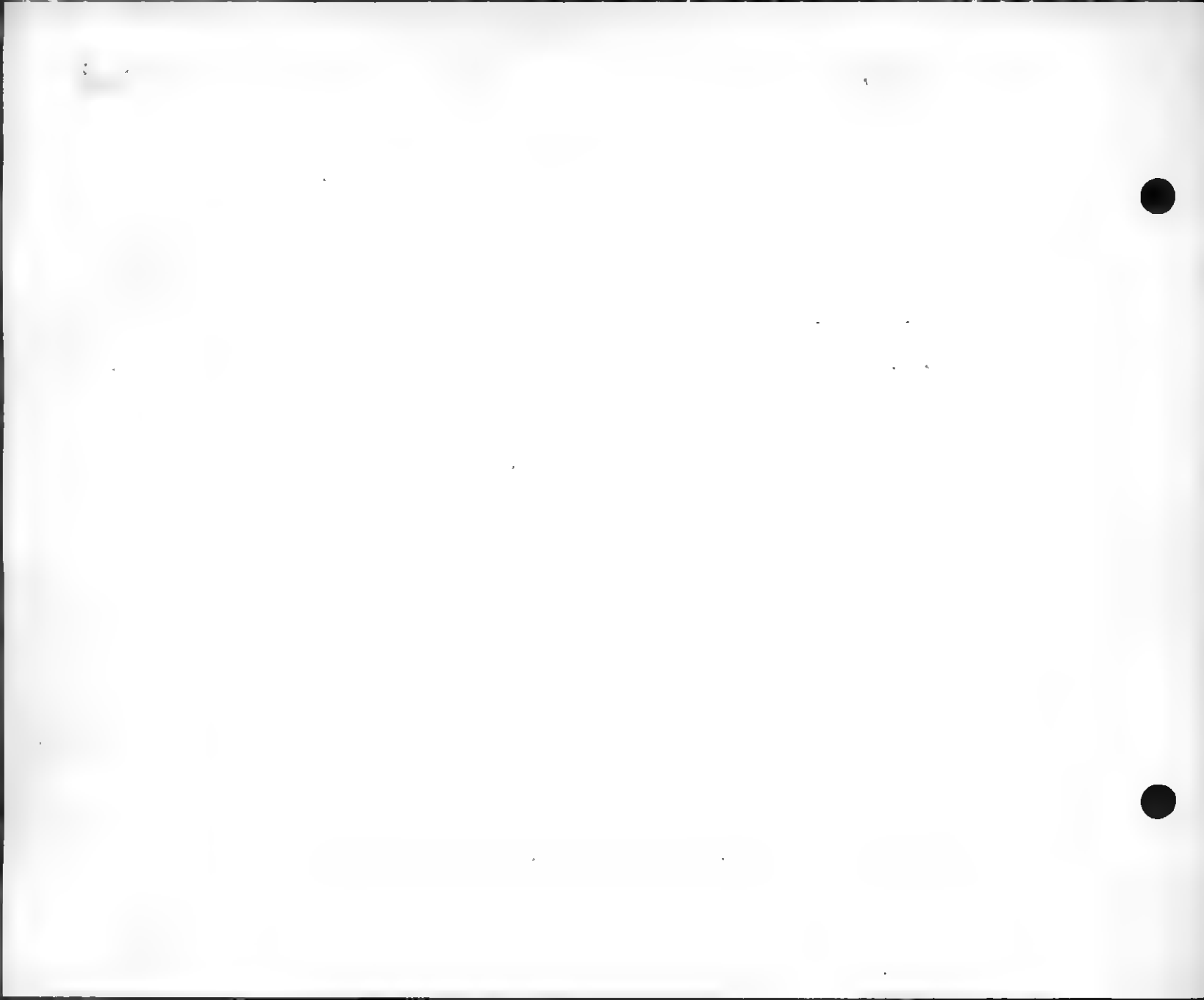
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15094

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form IM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE NEW YORK b COUNTY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) North Arundel		c LENGTH OF STAY IN 1b Webster	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d STREET ADDRESS 818 Ridge Road	
3 NAME OF DECEASED (Type or print) First Middle Last AGNES S KLAVER		4 DATE OF DEATH Month Day Year November 10 19 66	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/11/94
9 AGE (In years last birthday) yrs. 72		10 IF UNDER 1 YEAR Months Days Hours Min 19 66	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SCHOOLTEACHER		10b KIND OF BUSINESS OR INDUSTRY INDUSTRY	
11 BIRTHPLACE (State or foreign country) NEW YORK		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME GEORGE SCHOEMAKER		14. MOTHER'S MAIDEN NAME ELIZABETH HERMAN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO -----	
17 INFORMANT MR. RICHARD KLAVER, NEWBURN, NORTH CAROLINA		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Transection of lower medulla DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver in truck-auto collision	
20c TIME OF INJURY Month, Day, Year Hour:Min 3:54 p.m. 11/10 19 66		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f (City or town) (County) (State) N. Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Springate</i> EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED November 11, 1966	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 11-14-66	
23c NAME OF CEMETERY OR CREMATORY WEBSTER RURAL CEMETERY		23d LOCATION (City or Town) (County) (State) WEBSTER, NEW YORK	
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue, 21229		25a REC'D BY REGISTRAR NOV 14 1966 DATE	
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

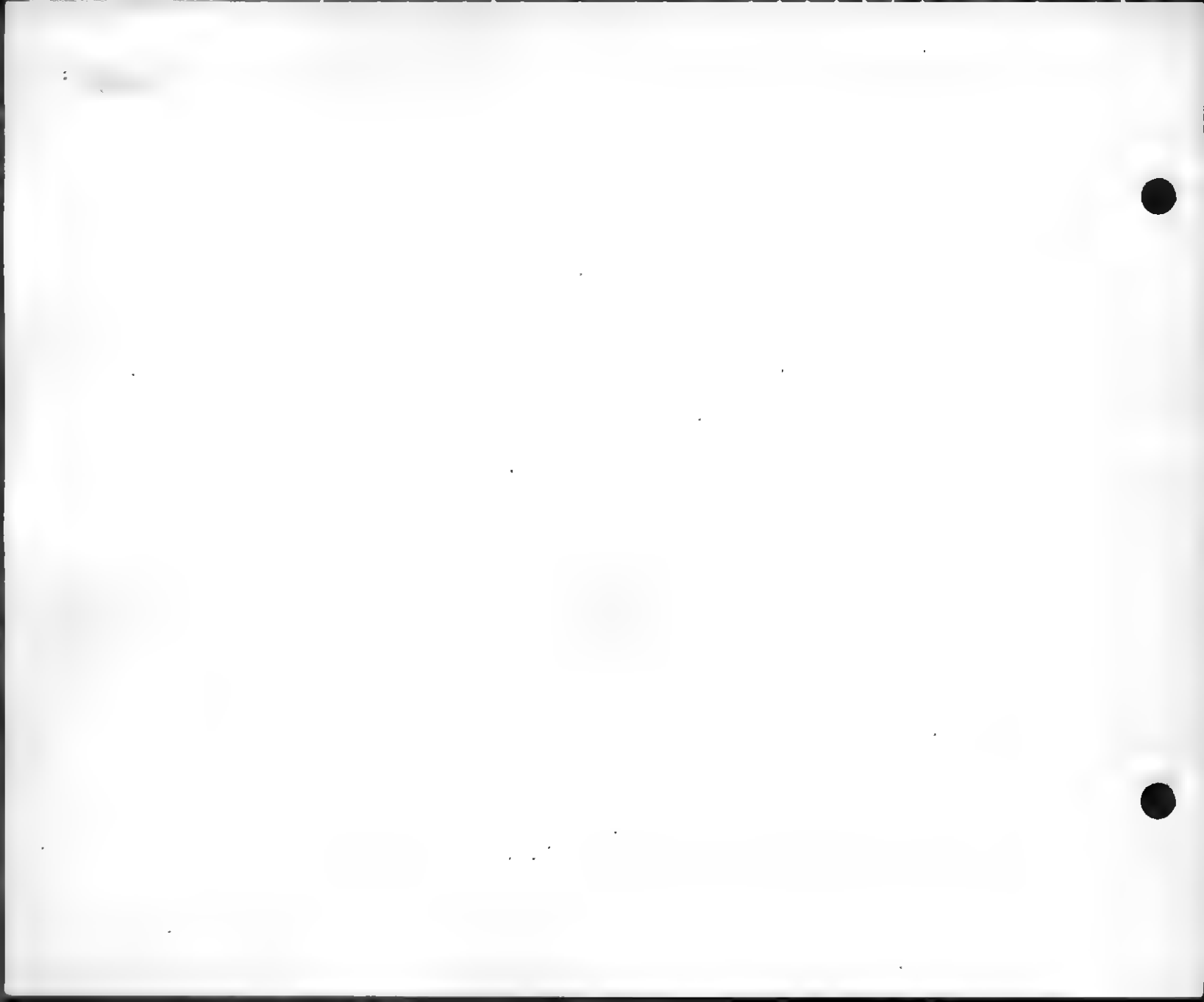
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15095

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE NEW YORK b. COUNTY NEW YORK		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Arundel		c. LENGTH OF STAY IN 1b Webster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Webster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital			d. STREET ADDRESS 818 Ridge Road		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) HERMAN HERMAN L. KLAVER			4 DATE OF DEATH Month Day Year November 10, 19 66		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/12/94	9 AGE (In years last birthday) 72 yrs	F UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - TIRE CO.		10b. KIND OF BUSINESS OR INDUSTRY -----		11 BIRTHPLACE (State or foreign country) NEW YORK	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			13 FATHER'S NAME JOHN F. KLAVER		
14 MOTHER'S MAIDEN NAME ROSALIA SULASKY			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W W I		
16 SOCIAL SECURITY NO 073-03-4999			17. INFORMANT Address MR. RICHARD KLAVER, NEWBURN, NORTH CAROLINA		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple severe injuries 3161 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in truck-auto collision			
20c. TIME OF INJURY Month, Day, Year 3:54 p.m. 11/10 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway	
20f. (City or town) North Arundel,		20g. (County) Md.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate		22. DATE SIGNED November 11, 1966		23. REGISTRAR'S SIGNATURE Charles Judge	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-14-66		23c. NAME OF CEMETERY OR CREMATORY WEBSTER RURAL CEMETERY	
23d. LOCATION (City or Town) WEBSTER, NEW YORK		23e. LOCATION (County) NEW YORK		23f. LOCATION (State) NEW YORK	
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue, 21229		ADDRESS		25. NEED BY REGISTRAR NOV 14 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

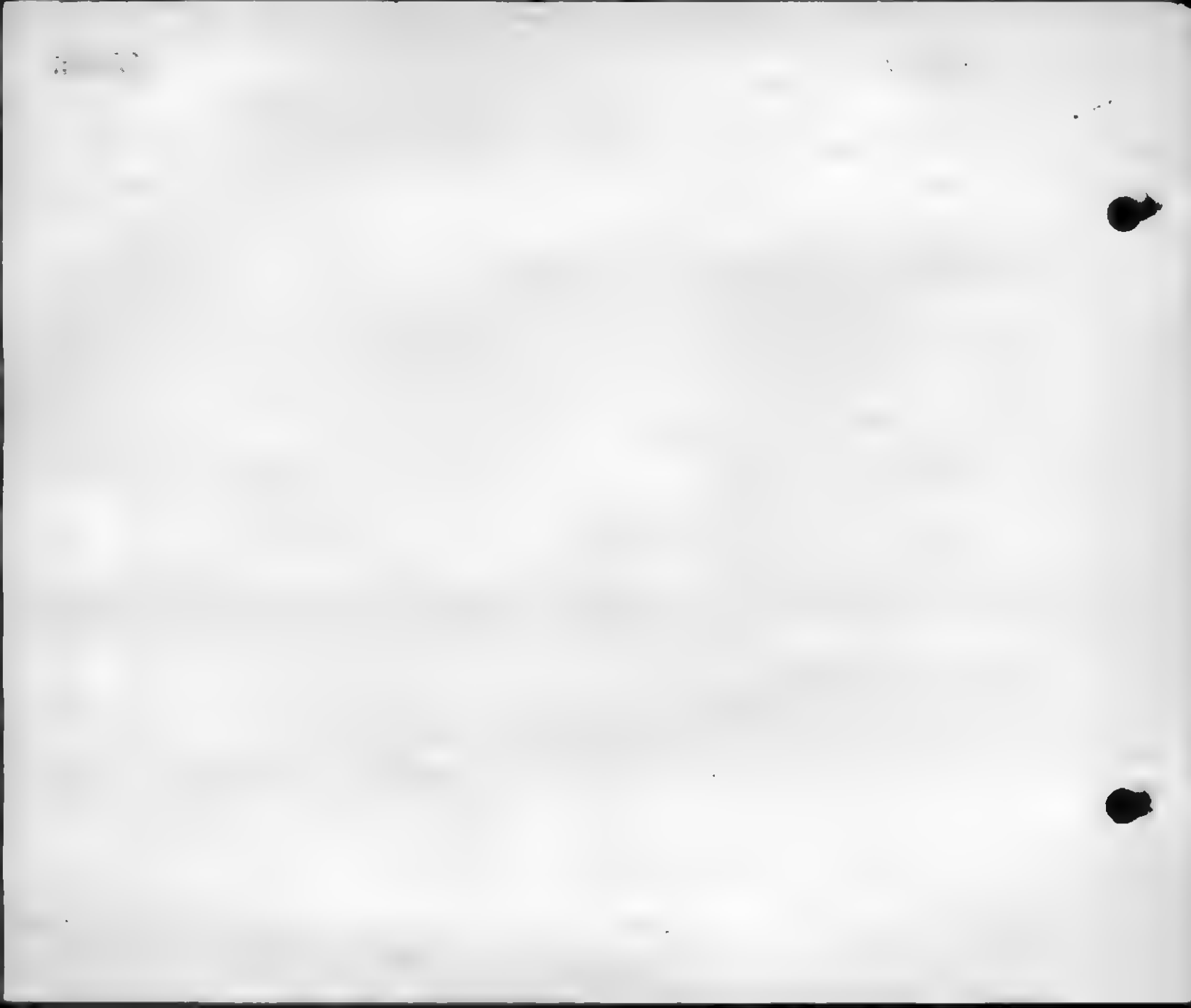
15096

CERTIFICATE OF DEATH

15096

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>11</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jordanville - Baltimore</u>		c. LENGTH OF STAY IN <u>17 yr -</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6 - Baltimore Ave.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
4. NAME OF DECEASED (Type or print) <u>John</u> First <u>George</u> Middle <u>Keenig</u> Last		4. DATE OF DEATH <u>Nov - 8</u> <u>1966</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov - 20 - 1902</u> <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto.</u>	
13. FATHER'S NAME <u>George Henry Keenig</u>		14. MOTHER'S MAIDEN NAME <u>Leann Hoppenan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-058289</u>	
17. INFORMANT <u>Joseph & Keenig - Brother in Law</u>		18. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Vascular Disease</u> DUE TO (b) <u>Cancer of rt lung - Operated 2-3 yr</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last <u>to removal of lung Oct. 6 - 1966</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1960</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1964</u> to <u>Nov 8, 1966</u> , that (I) (we) last saw the deceased alive on <u>11/8/66</u> and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas. L. Ball, Jr.</u> M.D.		22b. DATE SIGNED <u>11/8/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles L. Ball, Jr. - M.D.</u>		22d. ADDRESS <u>Leitham, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 13, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 10 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of this certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

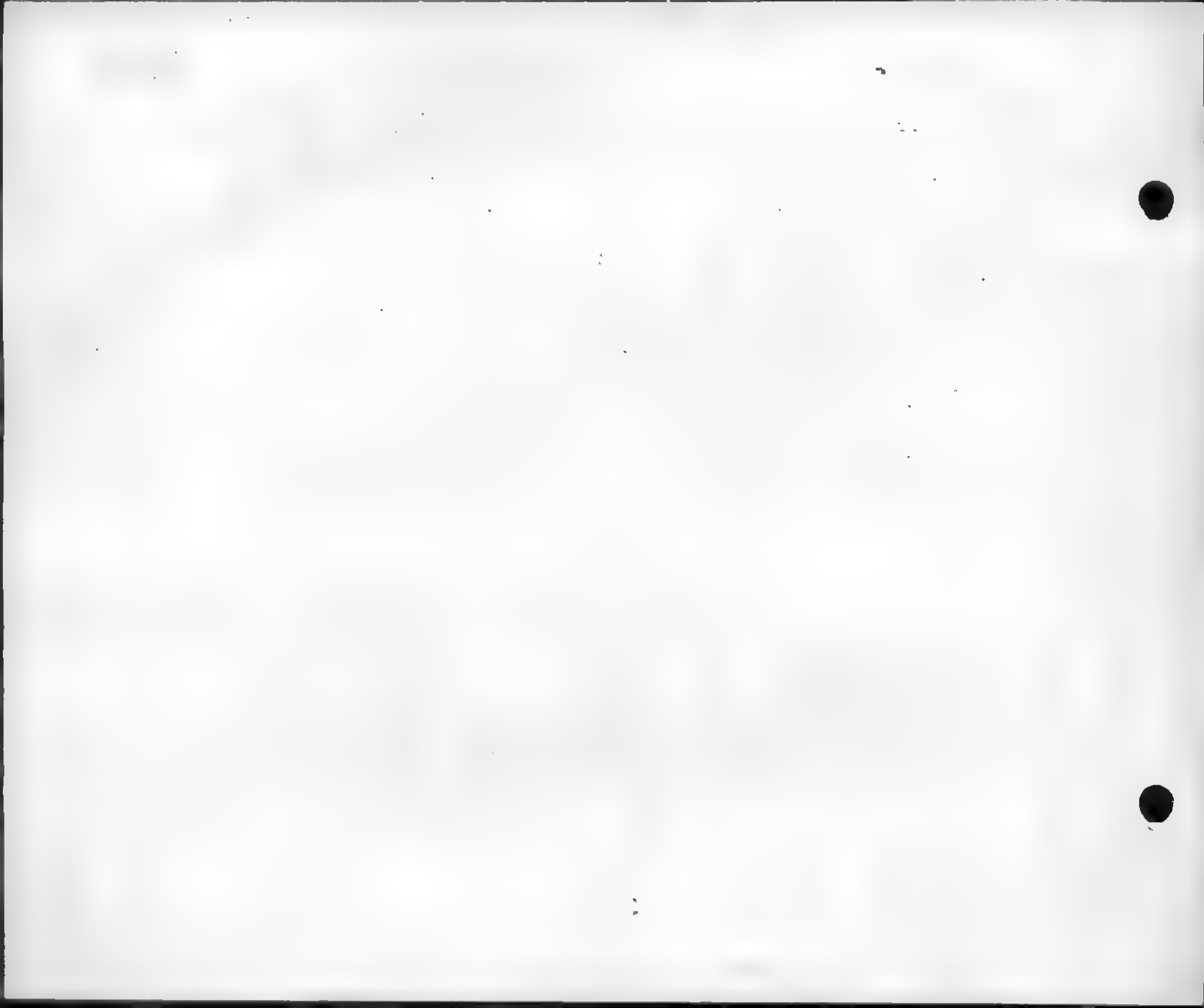
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15097

CERTIFICATE OF DEATH

15097

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 28 Bristol Dr.		d. STREET ADDRESS 28 Bristol Dr.	
3. NAME OF DECEASED (Type or print) First EDWARD Middle C. Last KUHL		4. DATE OF DEATH Month 11 Day 27 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-29-1908
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR Months 1 Days 27 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT		10b. KIND OF BUSINESS OR INDUSTRY FOOD	
11. BIRTHPLACE (County & State, or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME EDWARD A. KUHL		14. MOTHER'S MAIDEN NAME SADIE STAAB	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT GERTRUDE C. KUHL. #2		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Carcinoma of the Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/10 , 19 66 , to 11/26 , 19 66 , that (I) (we) last saw the deceased alive on 11/26/66 19 66 , and that death occurred at 3p M, from causes and on the date stated above.			
22a. SIGNATURE Gerard Blum		22b. DATE SIGNED 11/27/66	
22c. PHYSICIAN'S NAME (Type) Burns Robert		22d. ADDRESS 121 CATHERINE ST. ANNAPOLIS MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-30-66	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION (City or town) (County) (State) ANNAPOLIS A.A. MD.
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE NOV 29 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

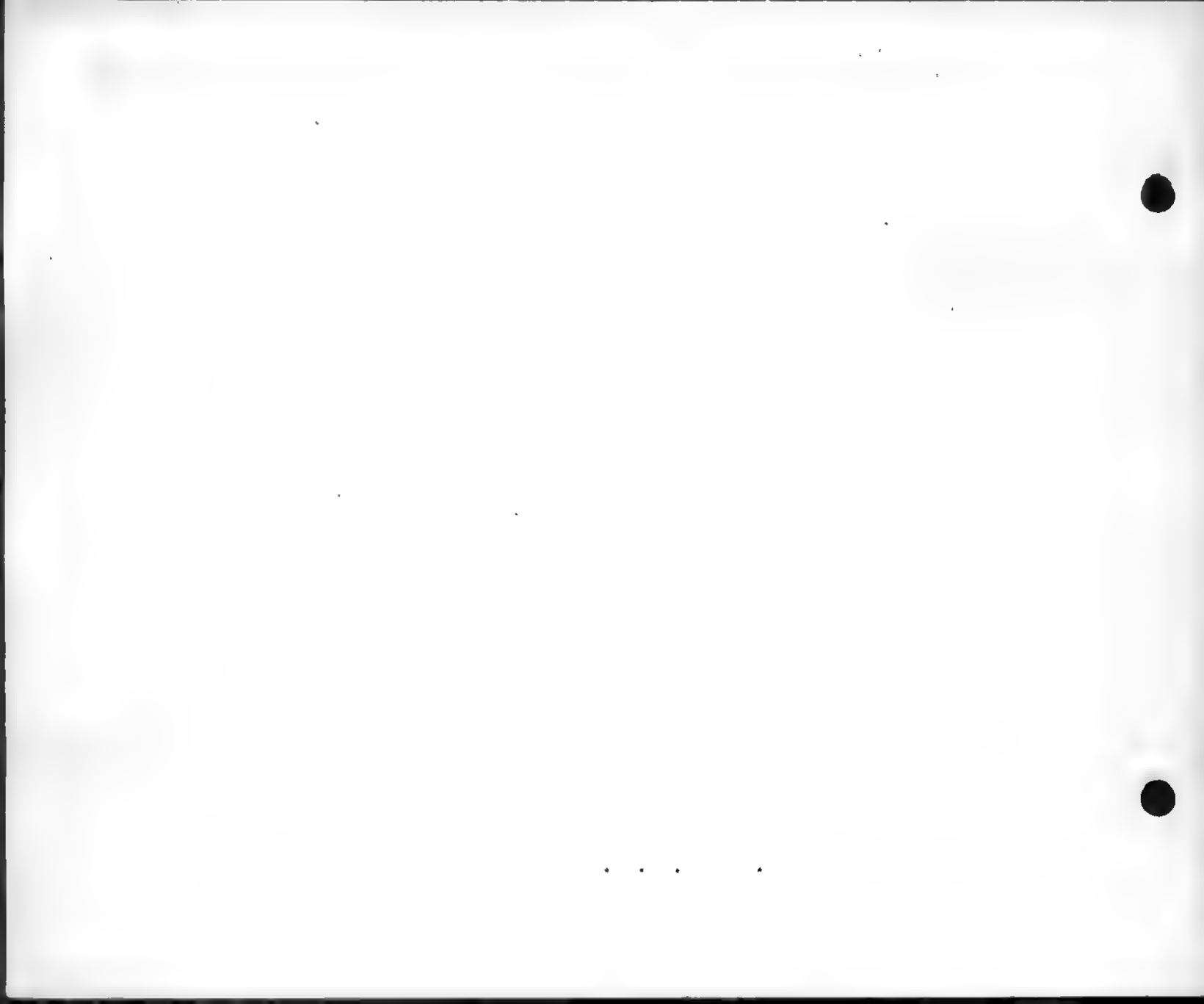
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15098

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15098

1 PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queens Town (Severn)</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queens Town (Severn)</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jones Road, Queens Town</u>		e STREET ADDRESS <u>Jones Road</u>	
3 NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>LAMONS</u> Last <u>LAMONS</u>		4 DATE OF DEATH Month <u>Nov</u> Day <u>7</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Colored</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH
9 AGE (In years last birthday) <u>44</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b KIND OF BUSINESS OR INDUSTRY	
11c BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO (If yes give war or dates of service)	
17 INFORMANT		Address	
18 CAUSE OF DEATH (Enter on any one cause per one for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>471X Bronchopneumonia, Bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatty alteration of Liver</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u> </u> am <u> </u> pm <u> </u> 19 <u> </u>		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>PARTIAL</u>		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held of Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D.		22. DATE SIGNED <u>Nov. 8th 1966</u>	
EXAMINER'S NAME (Type) <u>Werner U. Spitz, M. D.</u>		Address (Street, city, town, or county)	
23a BURIAL-CREMATATION (Specify)	23b DATE THEREOF <u>11.28.66</u>	23c NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>	23d LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR		25a RECD BY REGISTRAR	
ADDRESS		25b REGISTRAR'S SIGNATURE	
DATE		NOV 30 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15099

CERTIFICATE OF DEATH

15099

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HANOVER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH ARUNDEL HOSPITAL</u>				d. STREET ADDRESS <u>BOX 55</u>			
3. NAME OF DECEASED (Type or print) First <u>ALFRED</u> Middle <u>LONG</u> Last <u>LONG</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>30</u> Year <u>1966</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEBRUARY 4, 1882</u>		9. AGE (In years last birthday) <u>84 yrs.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ANNE ARUNDEL CO., MARYLAND</u>			
13. FATHER'S NAME <u>George Washington Long</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic acidosis</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Left ventricular failure</u> DUE TO <u>Arteriosclerotic heart disease</u> (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>1 day</u> <u>years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>11/27, 1966</u> to <u>11/30, 1966</u> , that (I) (we) last saw the deceased alive on <u>11/30, 1966</u> , and that death occurred at <u>4:45 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Max C Frank MD</u>		22b. DATE SIGNED <u>11/30/66</u>		22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK MD</u>			
22d. ADDRESS <u>4555 Ritchie Hwy - Glen Burnie MD</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>12/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Saints Rest</u>		23d. LOCATION (City or Town) (County) (State) <u>Harman Md.</u>			
24. FUNERAL DIRECTOR <u>Charles A. Rice</u>		ADDRESS <u>6612 W. Barnes St. City 30</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 1 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

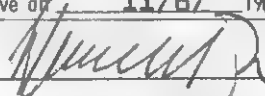

VR A15 (4)
20 M 1/66

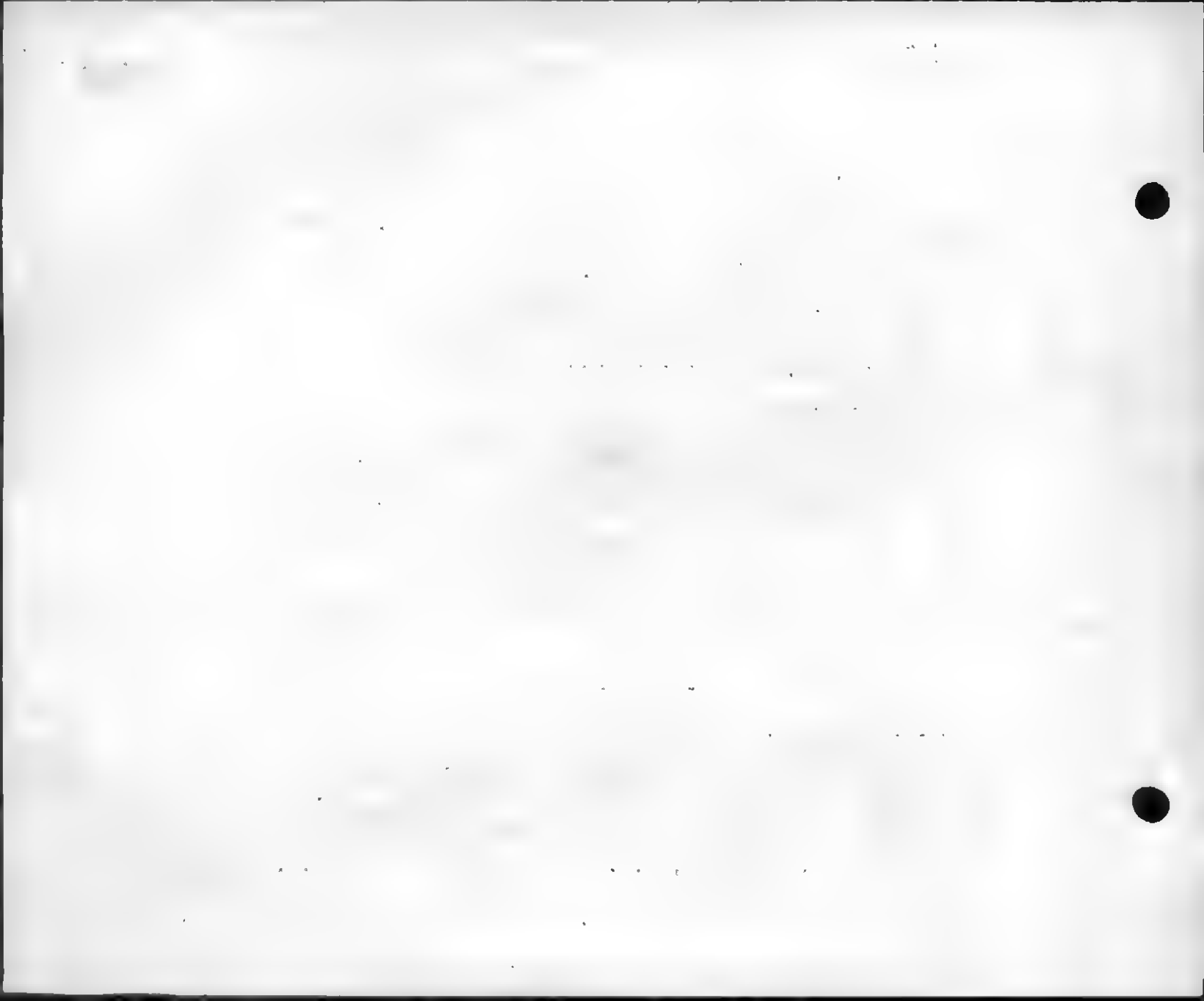
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15100

CERTIFICATE OF DEATH

15100

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY 	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c LENGTH OF STAY IN 1b 4 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e STREET ADDRESS 516 W. Mulberry	
3 NAME OF DECEASED (Type or print) #33732 William B. Lovett		4 DATE OF DEATH Month 11 Day 6 Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/15/1894
9 AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (ret.)		10b. KIND OF BUSINESS OR INDUSTRY -----	
11 BIRTHPLACE (County & State, or foreign country) Virginia TENN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Lovett		14. MOTHER'S MAIDEN NAME Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWI		16 SOCIAL SECURITY NO. 230-4019437 258-10-1437	
17 INFORMANT Hospital Records		Address AS 711	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----	
20c TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 11/2/ 1966 , to 11/6/ 1966 , that (I) (we) last saw the deceased alive on 11/6/ 1966 , and that death occurred at 7:45 M, from causes on and on the date stated above.			
22a SIGNATURE 		22b DATE SIGNED 11/7/66	
22c PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d ADDRESS Crownsville P.O., Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/10/66	23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Balto., Md. 21202		25a. REC'D BY REGISTRAR DATE NOV 9 1966	
Wm. Cook-Bfooks F.H. 1217 St. Paul St.		25b REGISTRAR'S SIGNATURE 	



1

15101

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

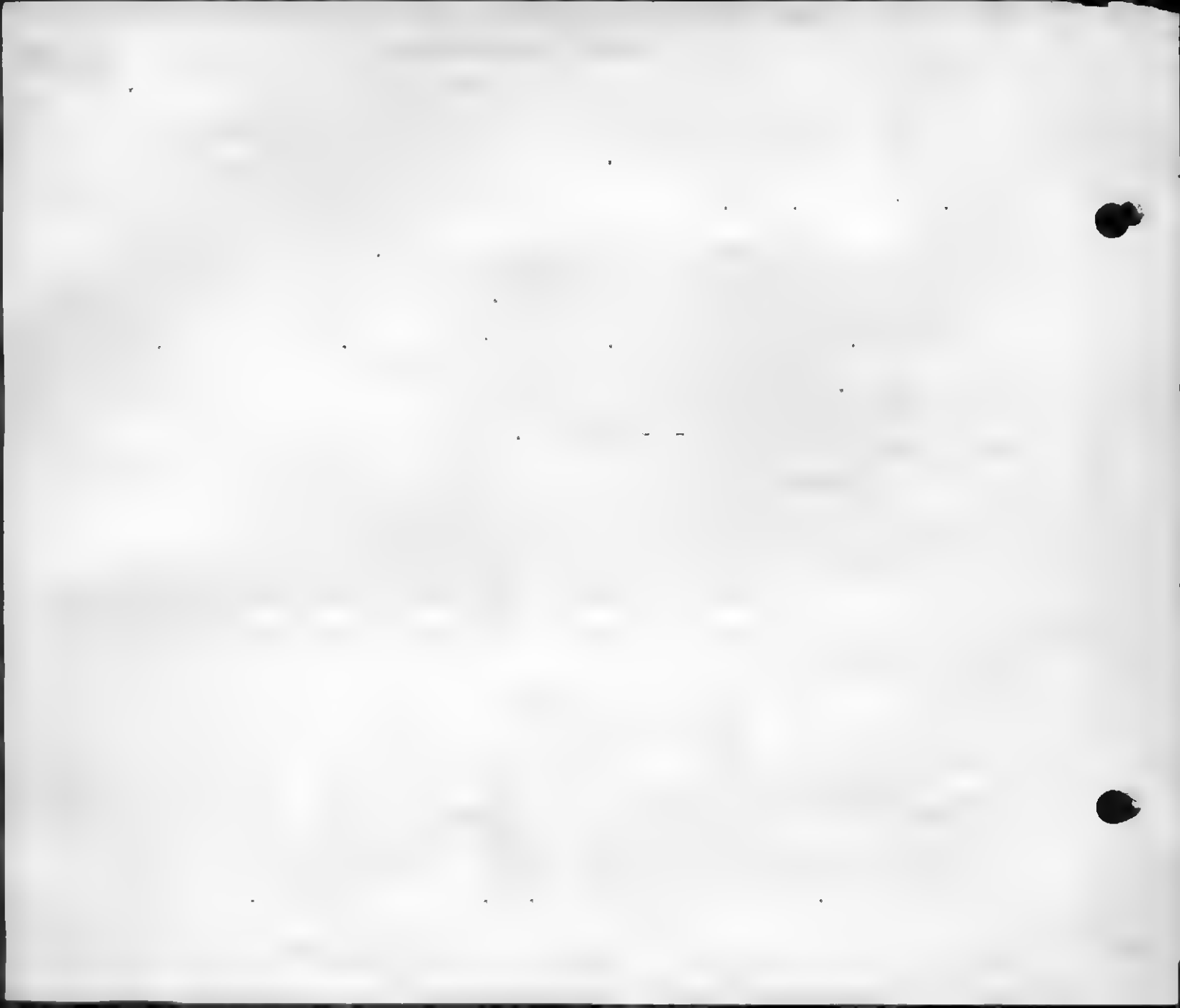
CERTIFICATE OF DEATH

Reg. Dist. No.

15101

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				c. LENGTH OF STAY IN 1b 15 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION N. Arundel Gen. Hosp.				e. STREET ADDRESS Fairview Beach Road			
3. NAME OF DECEASED (Type or print) First Oscar Edward Middle LOWRY Last Sr.				4. DATE OF DEATH Month 11 Day 5 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1881	9. AGE (In years last birthday) 85 yrs	IF UNDER 1 YEAR Months 5 Days 10 Hours 4 Min 10	IF UNDER 24 HRS Months 5 Days 10 Hours 4 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer Ret.		10b. KIND OF BUSINESS OR INDUSTRY Lord Balto. Press		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James D. Lowry				14. MOTHER'S MAIDEN NAME Ida Bell Dulin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 215-01-3342		17. INFORMANT Mrs. Katherine Lowry		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month, 19	Day, 19	Year, 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Pasadena	(County) Anne Arundel
21. I certify that I attended the deceased from Oct. 20, 1966 , to Nov. 5, 1966 , that I last saw the deceased alive on Nov. 4, 1966 , and that death occurred at 7:40 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Brady Smith				ADDRESS (Street, city or town, state) 8471 F. SMALLWOOD RD PASADENA, MD			
PHYSICIAN'S NAME (Type) D. BRADY SMITH				DATE SIGNED 11/7/66			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 8, 1966	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce				ADDRESS 4001 Ritchie Hwy. (21225)		24a. REC'D BY REGISTRAR NOV 10 1966	24b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15102

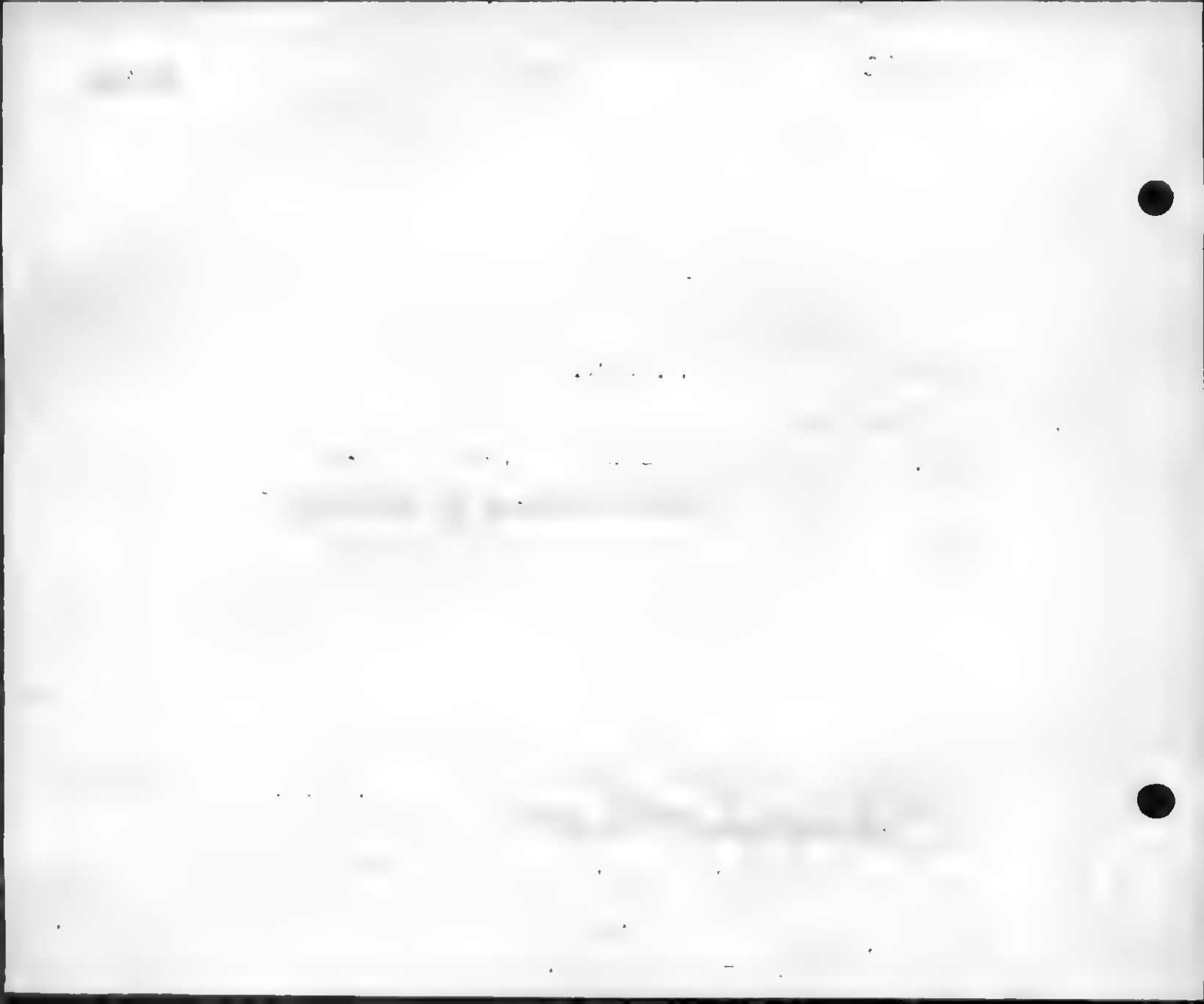
CERTIFICATE OF DEATH

15102

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS 13 Monroe Ct.	
3 NAME OF DECEASED (Type or print) First Middle Last Nicholas LUONGO		4. DATE OF DEATH Month Day Year November 13 19 66	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 13, 1902
9. AGE (In years last birthday) 63 yrs		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pressman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Luongo		14. MOTHER'S MAIDEN NAME Theresa (maiden name unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no.		16. SOCIAL SECURITY NO 216-44-9286	
17. INFORMANT Mrs. Josephine Luongo-		Address Same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Carcinoma of Lung		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 26 OCT, 1966 to 13 NOV, 1966 that (I) (we) last saw the deceased alive on 12 NOV 1966 , and that death occurred at 2:05 A.M. from causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 2:05 A.M.	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, Md.		22d. ADDRESS Franklin St., Annapolis, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/16/66	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis, Md.
24. FUNERAL DIRECTOR Beverly L. Hopping Hopping Funeral Home - Annapolis, Md.		25a. REC'D BY REGISTRAR NOV 16 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film 3382 11/11/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15104

15104

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>A.A. CO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u></u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - NEWBURNIE</u>		c LENGTH OF STAY IN 1b <u>Baltimore</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. NORTH ARUNDEL</u>		d STREET ADDRESS <u>1219 Hadwin Street</u>	
3 NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>E</u> Last <u>MacKENZIE</u>		4 DATE OF DEATH Month <u>NOV</u> Day <u>9</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-15-20</u>
9 AGE (In years last birthday) <u>46</u> yrs		10 IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fore Lady</u>		12 CIT ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Henry Clay Evans</u>		14 MOTHER'S MAIDEN NAME <u>Anna Martin</u>	
15 WAS DECEASED IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war and dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>unknown</u>	
17 INFORMANT <u>W. L. Evans, Brother</u>		Address <u>Severna Park, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m. <u></u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Linhart</u> EXAMINER'S NAME (Type) <u>E. L. Linhart</u>		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>NOV 9-66</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE THEREOF <u>11/14/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Hill Memorial Park, Landburg, Pa.</u>	
24. FUNERAL DIRECTOR <u>Thomas M. Lawrence</u>		25a. RECD BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



FOR STATE
HEALTH DEPT.

15105

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

15105

1. PLACE OF DEATH a. COUNTY <u>AACO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AACO</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Crawfish Hgts</u>	
c. LENGTH OF STAY IN 1b <u>1 Day</u>		d. STREET ADDRESS <u>RL 2 - Box 396</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A - Anne Arundel Gen</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rachel F. MANIGAN</u>		4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-1915</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Union, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andy Manigan</u>		14. MOTHER'S MAIDEN NAME <u>Winnie Manigan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>UNK.</u>	
17. INFORMANT <u>Christine Miller</u>		Address <u>Earl Hgts, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chylous ascites due to carcinoma</u> <u>143X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Franklin</u>		DATE SIGNED <u>11-11-66</u>	
EXAMINER'S NAME (Type) <u>F. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-17-66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Union, S.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Morton + Dett</u>		ADDRESS <u>1701 LAURENS ST.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 14 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

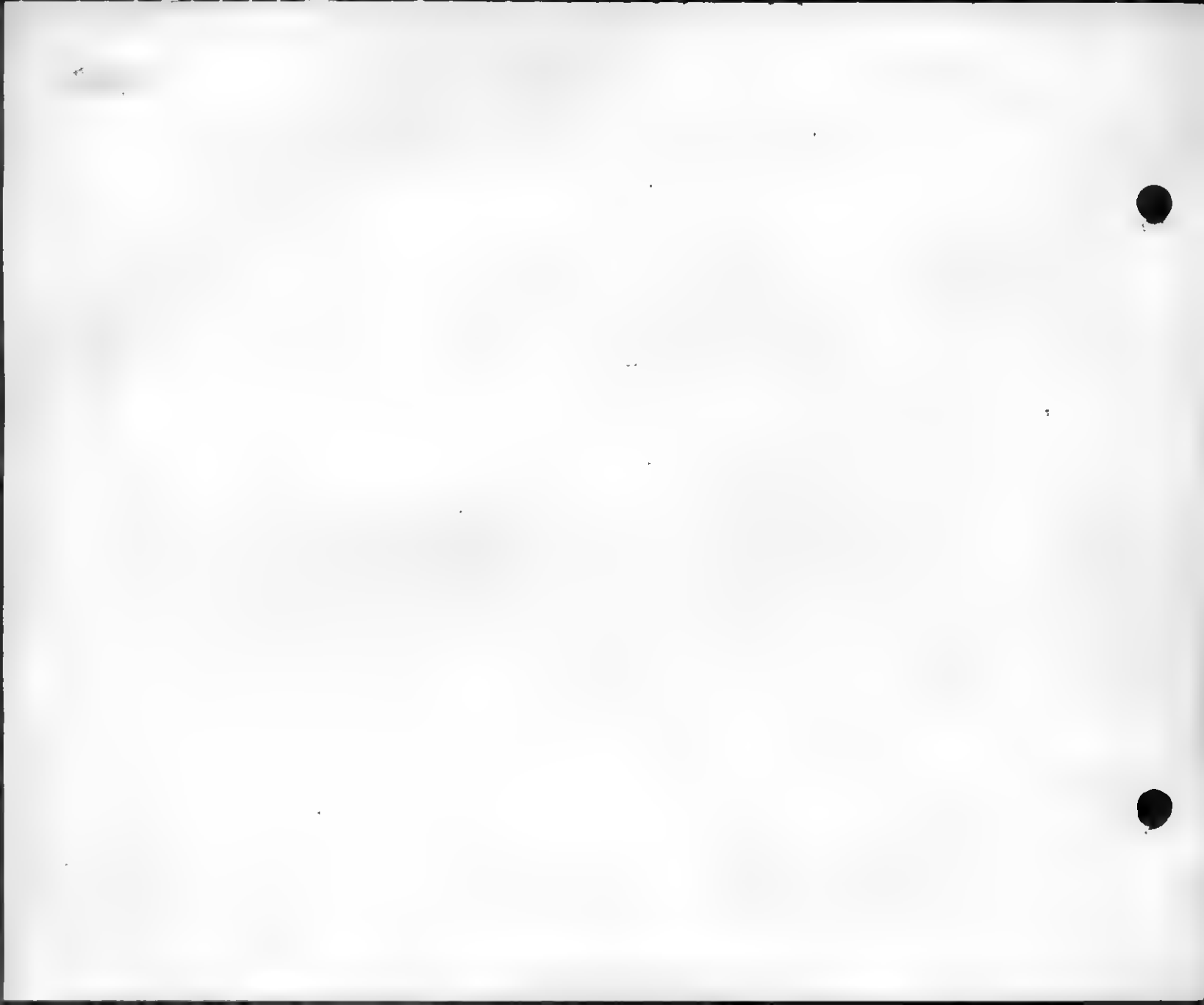
15106

CERTIFICATE OF DEATH

15106

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY in 1b 26 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 1613 Caroline Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #16395 Paul		First Middle Last		4. DATE OF DEATH March 11/ 28 19 66		Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/1934		9. AGE (In years lost birthday) 32 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carrington March				14. MOTHER'S MAIDEN NAME Georgia			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Peritonitis 5/78X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforation of Upper third of Jejunum DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Mental Deficiency						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9/27/1940 , to 11/28/1966 , that (I) (we) last saw the deceased alive on 11/28/1966 , and that death occurred at 11:00 from causes and on the date stated above							
22a. SIGNATURE <i>Hildegard Heard Reiss</i> M.D.		22b. DATE SIGNED 11/28/66		22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/2/66	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION (City or Town) (County) (State) Ann Arundel County Md.		
24. FUNERAL DIRECTOR WM. C. MARCH		ADDRESS 928 E. North Ave.		25a. REC'D BY REGISTRAR DEC 1 1966		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

VR A15ME (5)
6M 1/66

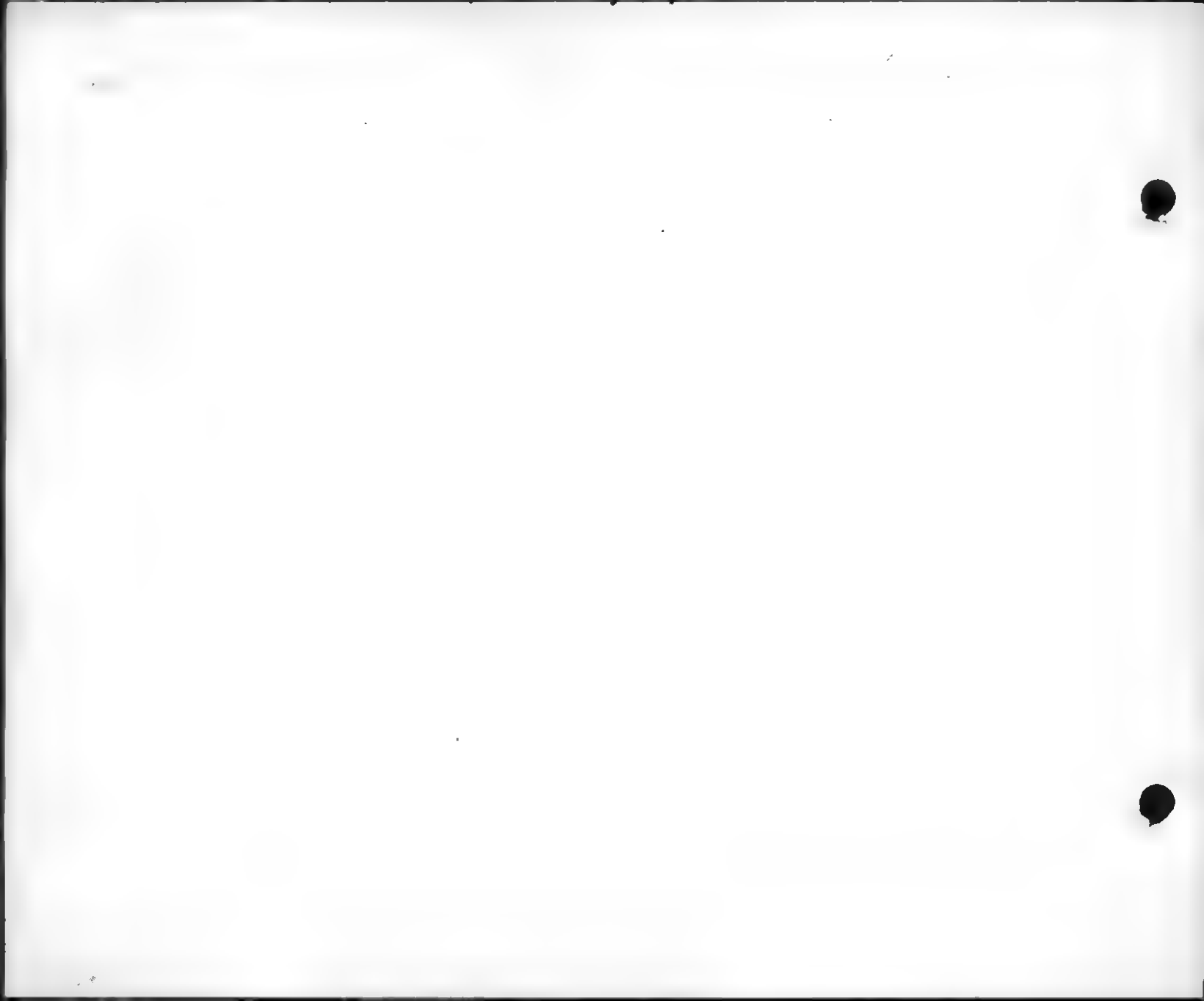
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15107

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15107

1 PLACE OF DEATH a. COUNTY <u>D.A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green BURNIE</u>		c LENGTH OF STAY N 1b <u>7 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORFOLK HOSPITAL - HOSPITAL</u>		e STREET ADDRESS <u>RFD #1 - Riverside Dr - Pasadena</u>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Marlow</u> Last <u>Marlow</u>		4 DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/17/89</u>
9 AGE (In years last birthday) yrs <u>77</u>		10 F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months <u>11</u> Days <u>13</u> Hours <u>19</u> Min <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11 BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>216-10-8606</u>	
17 INFORMANT <u>Welfare Records - Annapolis, Md.</u>		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis general</u> DUE TO <u>heart disease</u> (b) <u>myocardial infarction</u> DUE TO <u>coronary artery disease</u> (c) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fracture femur left</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10:00</u> p.m. <u>1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>PACU MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		22. DATE SIGNED <u>11/13/66</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>11/15/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Bentley E. Hopping</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Hopping & Sons, 1100</u>		DATE <u>NOV 17 1966</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

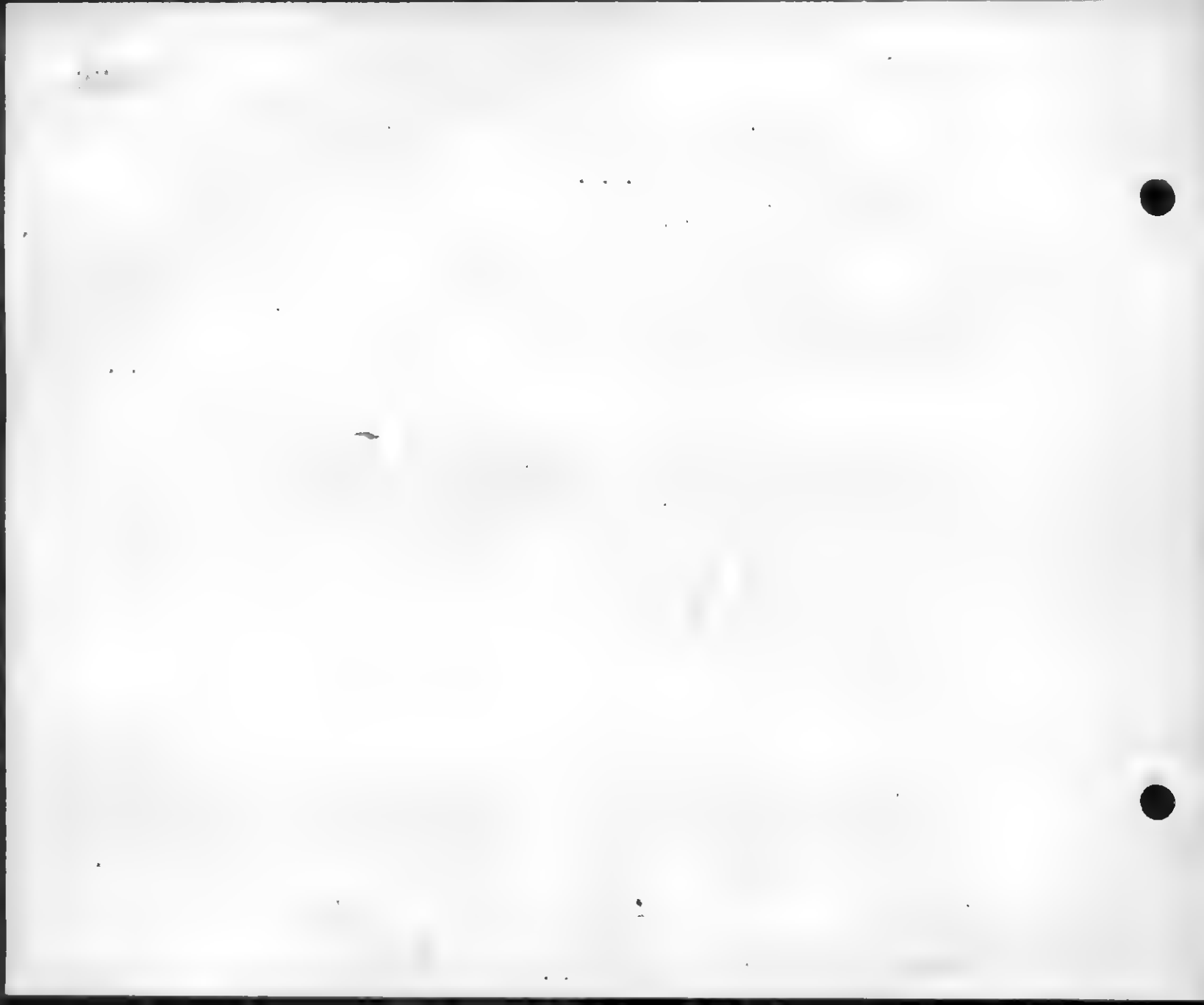
15108

CERTIFICATE OF DEATH

15108

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital (Dead on arrival)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater d. STREET ADDRESS Box-282 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Edward Middle Riley Last MARTIN			4 DATE OF DEATH Month November Day 10 Year 19 66				
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-10-1899	9 AGE (In years last birthday) 67 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN		10b. KIND OF BUSINESS OR INDUSTRY MUSICIAN		11 BIRTHPLACE (County & State, or foreign country) Scotland	12 CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME WILLIAM MARTIN			14. MOTHER'S MAIDEN NAME HELEN MOFFOTT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 134-07-183		17 INFORMANT Address Patricia M. Poth #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Aortic Stenosis & Chl. 4221 DUE TO Congestive Heart Failure - Sudden death. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO ASCVD or Rheumatic Heart Disease (c)					INTERVAL BETWEEN ONSET AND DEATH 5 years.		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus.					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (M.D. or D.O.) attended the deceased from March, 1966, to Nov., 1966, that (I) (M.D. or D.O.) last saw the deceased alive on 11-7-1966 and that death occurred at 11:30 AM from causes and on the date stated above.							
22a. SIGNATURE Peter F. Verkoren			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-10-66		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS 1407 Forest Drive, Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-13-1966		23c. NAME OF CEMETERY OR CREMATORY HILLCREST			
23d. LOCATION (City or Town) Annapolis		23e. (County)		23f. (State) MD.			
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD			25a. REC'D BY REGISTRAR NOV 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take the carbon papers, Pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
-FOR STATE
HEALTH DEPT.

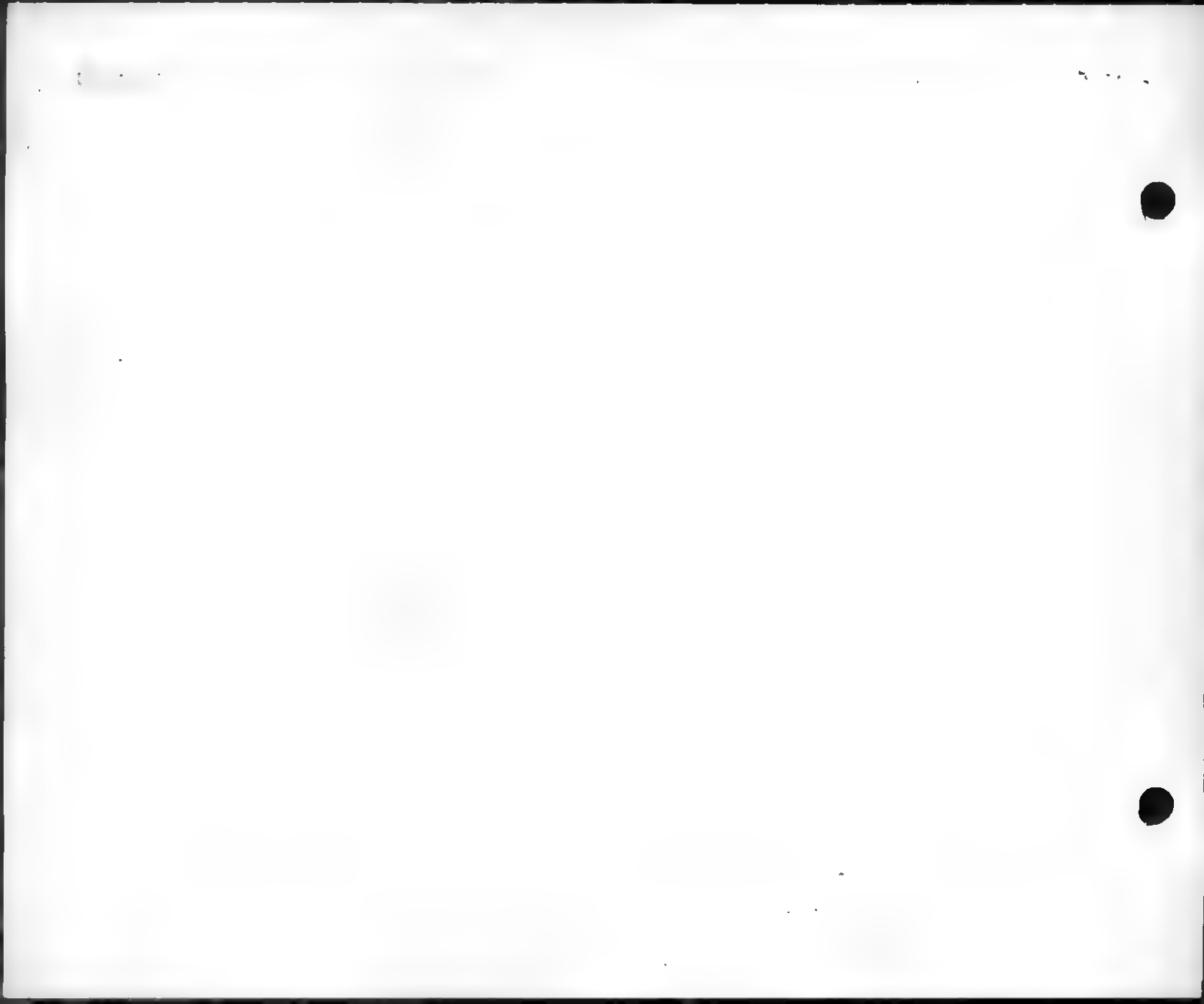
15109

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15109

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>MARCO</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived) Institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>MARCO</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O. N. NORTON H. ARUNDEL - Hosp</u>				d STREET ADDRESS <u>103-2nd AVE S.E.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Charles E. Masters</u>				4 DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1966</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-12-58</u>	9 AGE (in years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months <u>11</u> Days <u>30</u>		IF UNDER 24 HRS Hours <u>9</u> Min. <u>00</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ch Store-keeper (Ret)</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Coast Guard</u>		11 BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>(unknown) masters</u>				14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>1904-1939</u>		16 SOCIAL SECURITY NO <u>220-18-7888</u>		17 INFORMANT <u>Mrs. Nancy Dancy (Daughter)</u>		Address <u>SEVERNA PARK Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerosis general</u> <u>4-7-0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>Dec 3, 1966</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d LOCATION (City or Town) (County) (State) <u>Brockton, RFD. Md.</u>	
24 FUNERAL DIRECTOR <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>		25a REC'D BY REGISTRAR DATE <u>DEC 5 1966</u>		25b REGISTRAR'S SIGNATURE <u>James Judge</u>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

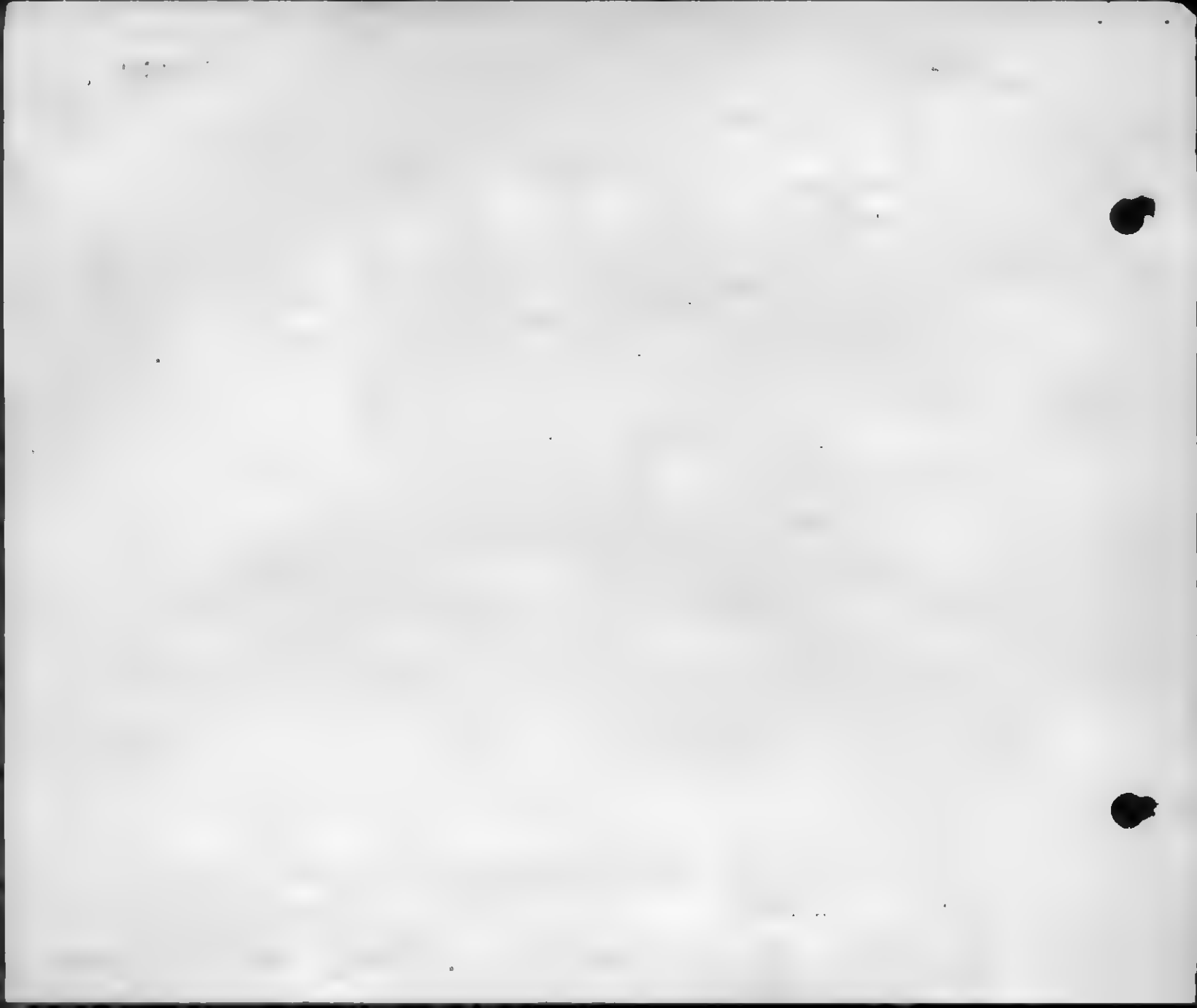
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

151110

151110

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN b. <u>21 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>612 Oakland Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>612 Oakland Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maggie May Matthews</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 7, 1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Bevans</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Beatrice Matthews, Glen Burnie, Md.</u>		Address <u>612 Oakland Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Competitive heart Failure</u> DUE TO (b) <u>Hypertensive cv Disease</u> (c) <u>Arteriosclerosis General</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 29, 1966</u> to <u>Nov 6, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 29, 1966</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Taler</u>		22b. DATE SIGNED <u>11/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH TALER</u>		22d. ADDRESS <u>95 ALEXANDER Rd. Glen Burnie Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-9-1966</u>	23c. NAME OF CEMETERY <u>First Baptist</u>	23d. LOCATION (City, town or county) (State) <u>Pocomoke City, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Pocomoke City, Md.</u>		DATE <u>NOV 14 1966</u>	

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15111

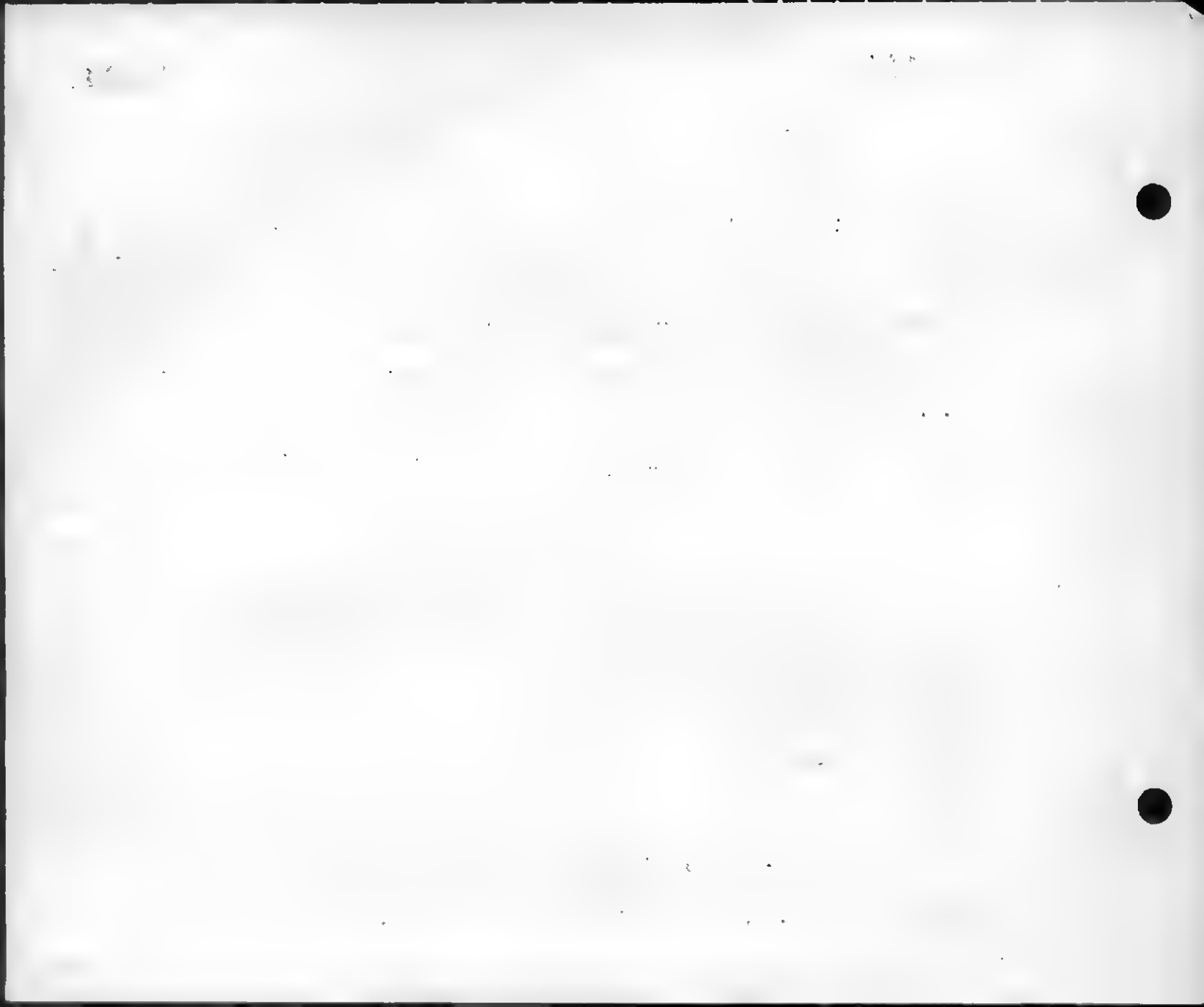
CERTIFICATE OF DEATH

15111

1 PLACE OF DEATH a COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ANNE ARUNDEL	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE		c LENGTH OF STAY IN 1b 62 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last GEORGIA ELIZABETH McCARTY		4 DATE OF DEATH Month Day Year NOVEMBER 7 19 66	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 14 MAY 1921
9 AGE (In years last birthday) yrs 45		10 UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (County & State, or foreign country) Trotman, Georgia		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME G.B. Ammons		14 MOTHER'S MAIDEN NAME Josie D. MEEKS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No N/A		16 SOCIAL SECURITY NO 418-12-3162	
17 INFORMANT Wm McCarty, Jr.		Address Route #2, Box 241-A, Severn, Md	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal Varices DUE TO (b) Laenne's Cirrhosis DUE TO (c) Nutritional Cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 Months 1 Year
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 8 Sept , 19 66 , to 7 Nov , 19 66 that he (we) last saw the deceased alive on 7 Nov , 19 66 , and that death occurred at 7:05 a.m. , from causes and on the date stated above.			
22a SIGNATURE Stuart H. Brager, Cpt, MC M.D.		22b DATE SIGNED 7 November 1966	
22c PHYSICIAN'S NAME (Type) STUART H. BRAGER, CPT, MC		22d ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF Nov. 10, 1966	23c NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.	23d LOCATION (City or Town) (County) (State) ARLINGTON VIRGINIA
24 FUNERAL DIRECTOR Harold S. Ward, Samuel, Inc		25a REC'D BY REGISTRAR DATE NOV 15 1966	25b REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Page 4 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15112

CERTIFICATE OF DEATH

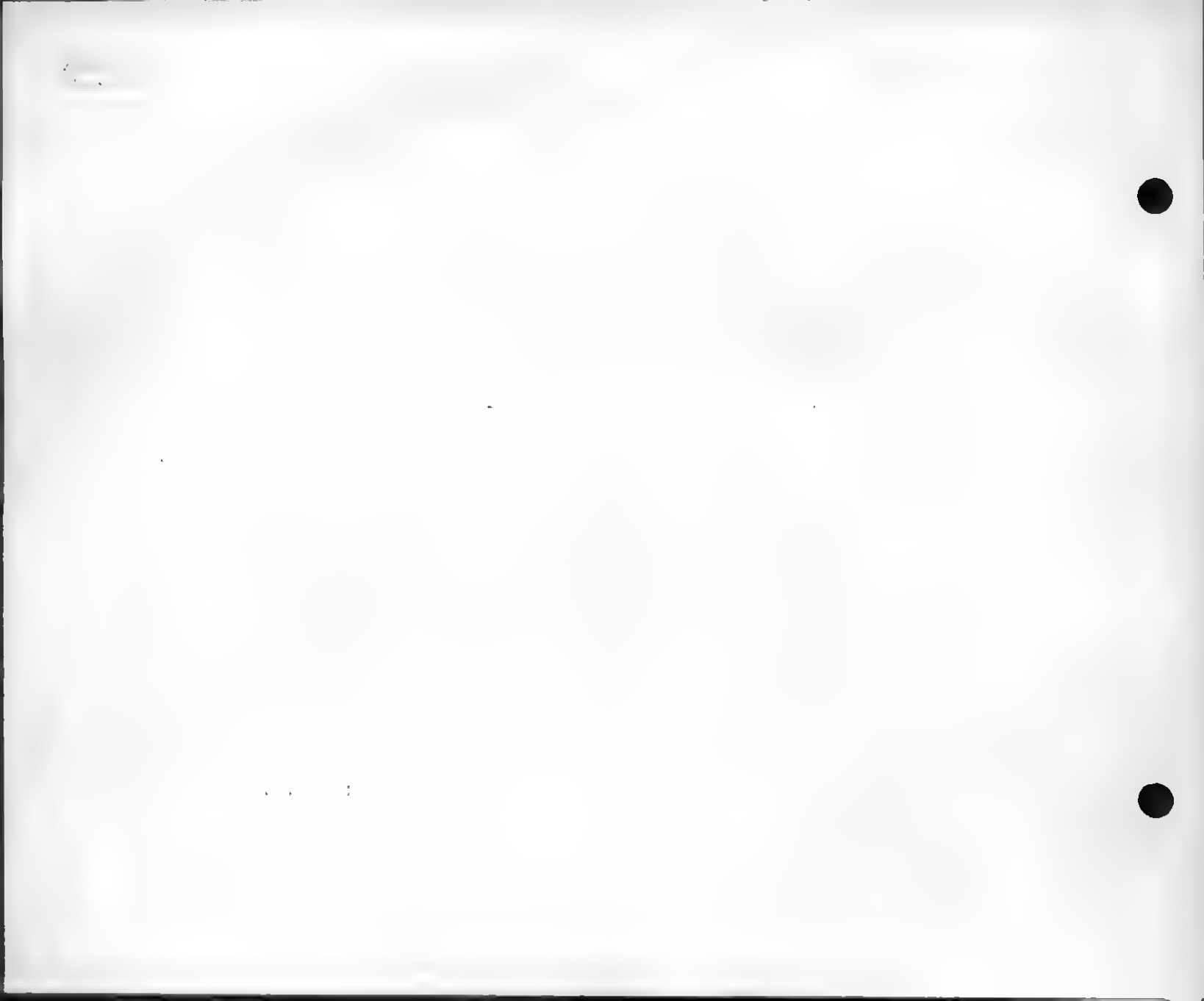
15112

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Annopolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 3 Murray Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last Clarence Bayne MC CRANE		4 DATE OF DEATH Month Day Year November 14 19 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH November 14, 1892
9 AGE (in years last birthday) 74 yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b KIND OF BUSINESS OR INDUSTRY USNMC	
11 BIRTHPLACE (County & State or foreign country) New Jersey		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME JAMES J. M^c CRANE		14 MOTHER'S MAIDEN NAME MARGARET JOHNSON	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NBS		16 SOCIAL SECURITY NO. WAT	
17 INFORMANT MRS. NELLIE M. M^c CRANE # 2		Address	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure 4-2-11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days Unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/2 , 19 62 , to 11/14 , 19 66 , that (I) (we) last saw the deceased alive on 11/14 , 19 66 , and that death occurred at 12:30 P.M. from causes and on the date stated above			
22a SIGNATURE Richard I. Hochman M.D.		22b DATE SIGNED 11/15/66	
22c PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d ADDRESS 59 Franklin St., Annapolis, Md.	
23a BURIAL CREMATION, (Specify) BURIAL		23b DATE THEREOF 11-17-1966	
23c NAME OF CEMETERY OR CREMATORY ALL SAINTS CEM		23d LOCATION (City or Town) (County) (State) PHILADELPHIA PA.	
24 FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD		25a REC'D BY REGISTRAR NOV 17 1966	
25b REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their office remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15113

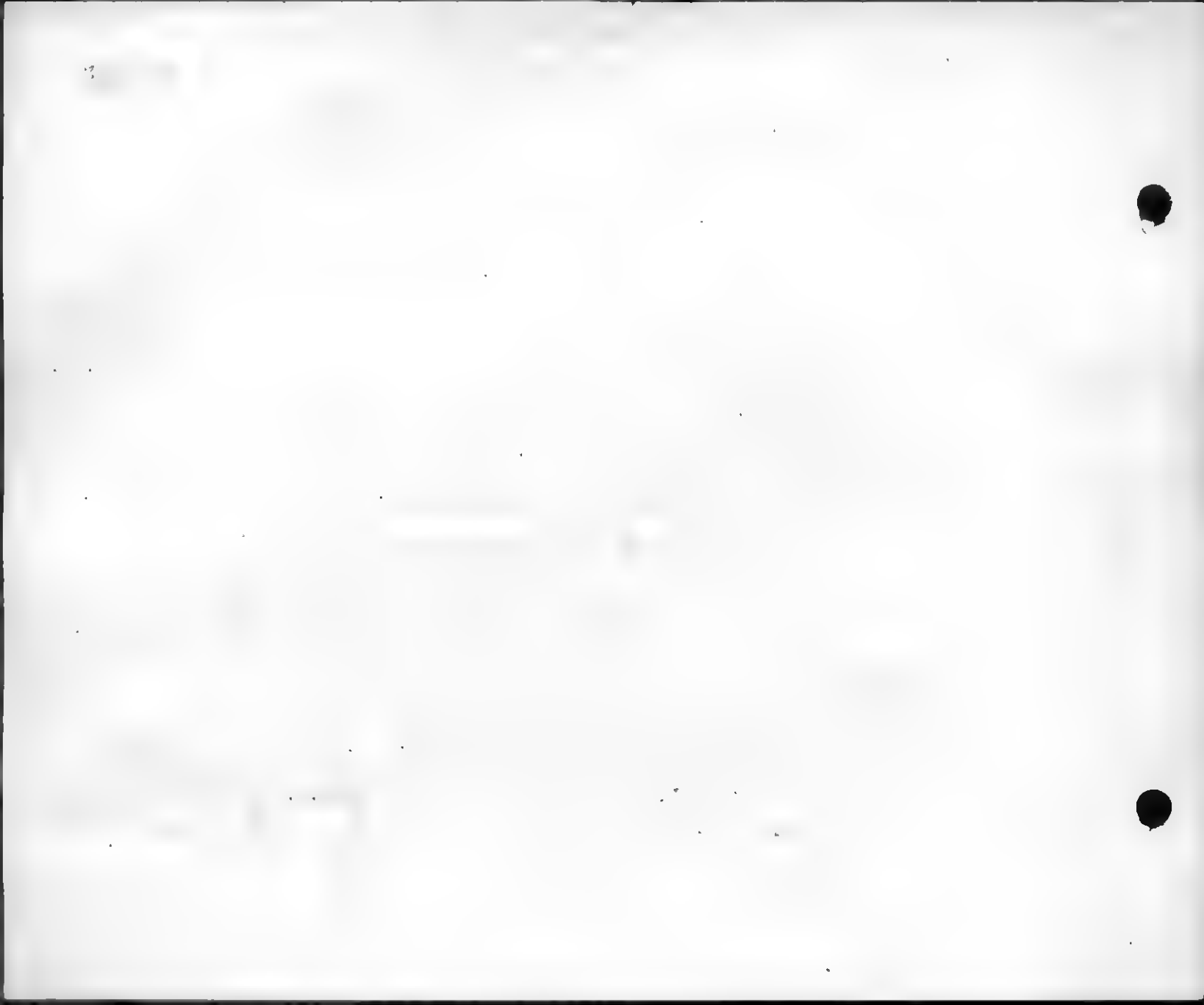
CERTIFICATE OF DEATH

15113

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN 1b Fairhaven	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt. 1, Box 258	
3 NAME OF DECEASED (Type or print) First John Middle Henry Last MITCHELL		4 DATE OF DEATH Month November Day 2 Year 1966	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 13, 1917
9 AGE (In years last birthday) 49 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U. S.		13 FATHER'S NAME Cornelius Mitchel	
14 MOTHER'S MAIDEN NAME Maggie Reid		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO. 216-285163		17 INFORMANT Isabel Mitchel, Fairhaven- Md.	
18 CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 145A DUE TO Hypertensive cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) unknown (c)			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 29, 1966 , to Nov. 2, 1966 , that (I) (we) last saw the deceased alive on Nov. 2, 1966 , and that death occurred at 5:02 P.M. from causes and on the date stated above			
22a. SIGNATURE Willard F. Smith M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/2/66
22c. PHYSICIAN'S NAME (Type) Willard F. Smith MD		22d. ADDRESS Stady Side, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 11-6-66	23c NAME OF CEMETERY OR CREMATORY Moses Cem.	23d LOCATION (City or Town) (County) (State) A.A. Co. Md.
24. FUNERAL DIRECTOR Pinkney E. Sewell ADDRESS Prince Frederick-Md		25a REC'D BY REGISTRAR DATE NOV 7 1966	25b REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

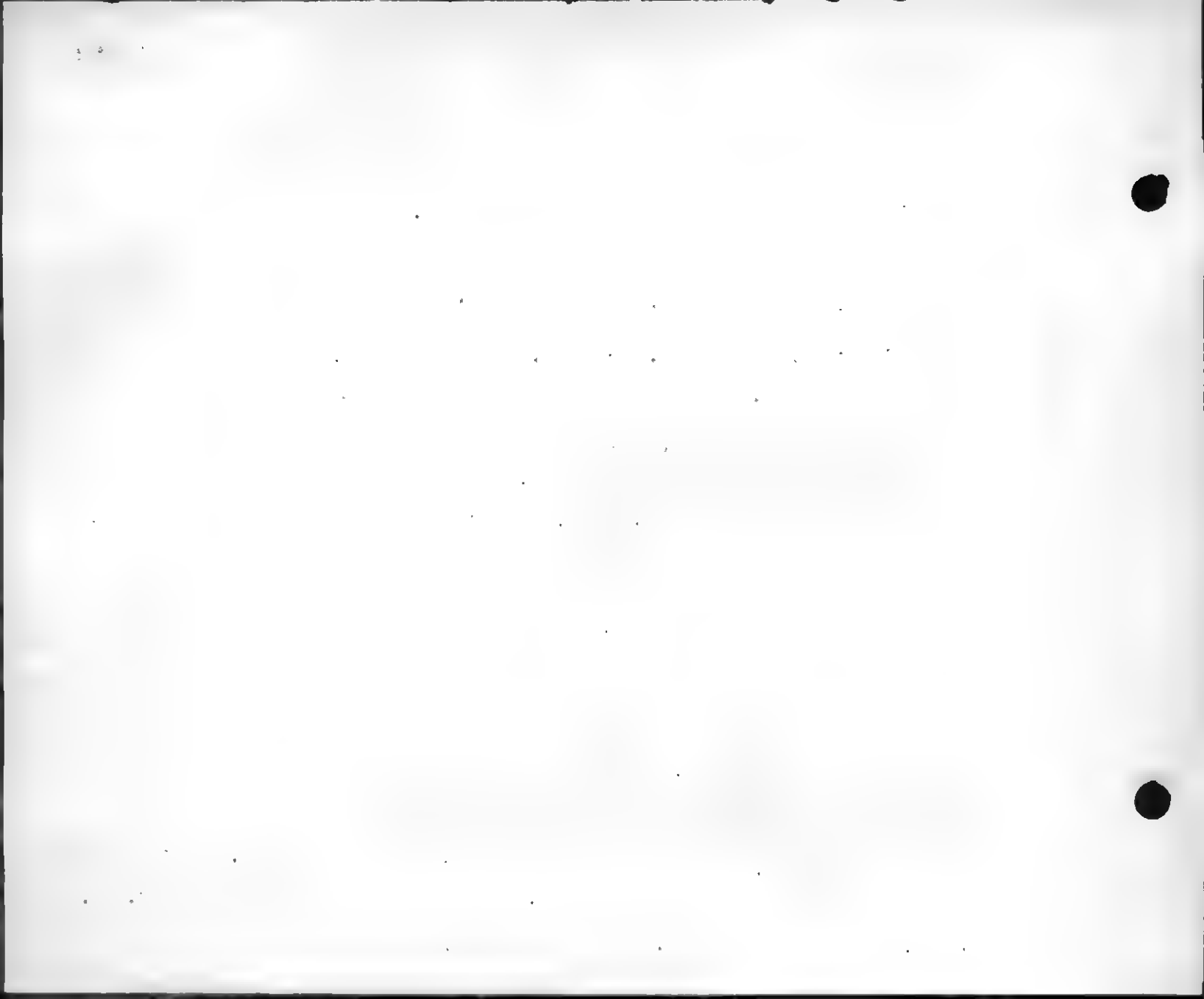
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>3</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Laurel Acres</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>---</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>402 E. Cross Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>William Thomas Moon</u> First Middle Last			4. DATE OF DEATH <u>11 27 1966</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dockhand 1st Cl.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>William T. Moon</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>215-09-4552</u> 17. INFORMANT <u>Family</u> 14. MOTHER'S MAIDEN NAME <u>Mary E. Anthony</u> Address <u>Same</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion <u>420.1</u> DUE TO <u>Arterio sclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus-----5 years</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____ </u>						
21. I certify that (I) (this hospital) attended the deceased from <u>6/3/61</u> , 19 <u>---</u> , to <u>11/7/66</u> , 19 <u>---</u> , that (I) (we) last saw the deceased alive on <u>11/25/66</u> , 19 <u>---</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
22a. SIGNATURE <u>Harry Deibel</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Harry Deibel, Md</u> 22d. ADDRESS <u>1226 S. Hanover St., Baltimore 30, Md.</u> 22b. DATE SIGNED <u>11/28/66</u>					23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11 30 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> 23d. LOCATION (City, town or county) (State) <u>Brooklyn, A. A. Co. Md.</u>				
24. FUNERAL DIRECTOR <u>McCully Funeral Home, 130 E. Fort Ave., Balto. Md.</u> ADDRESS					25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>NOV 30 1966</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

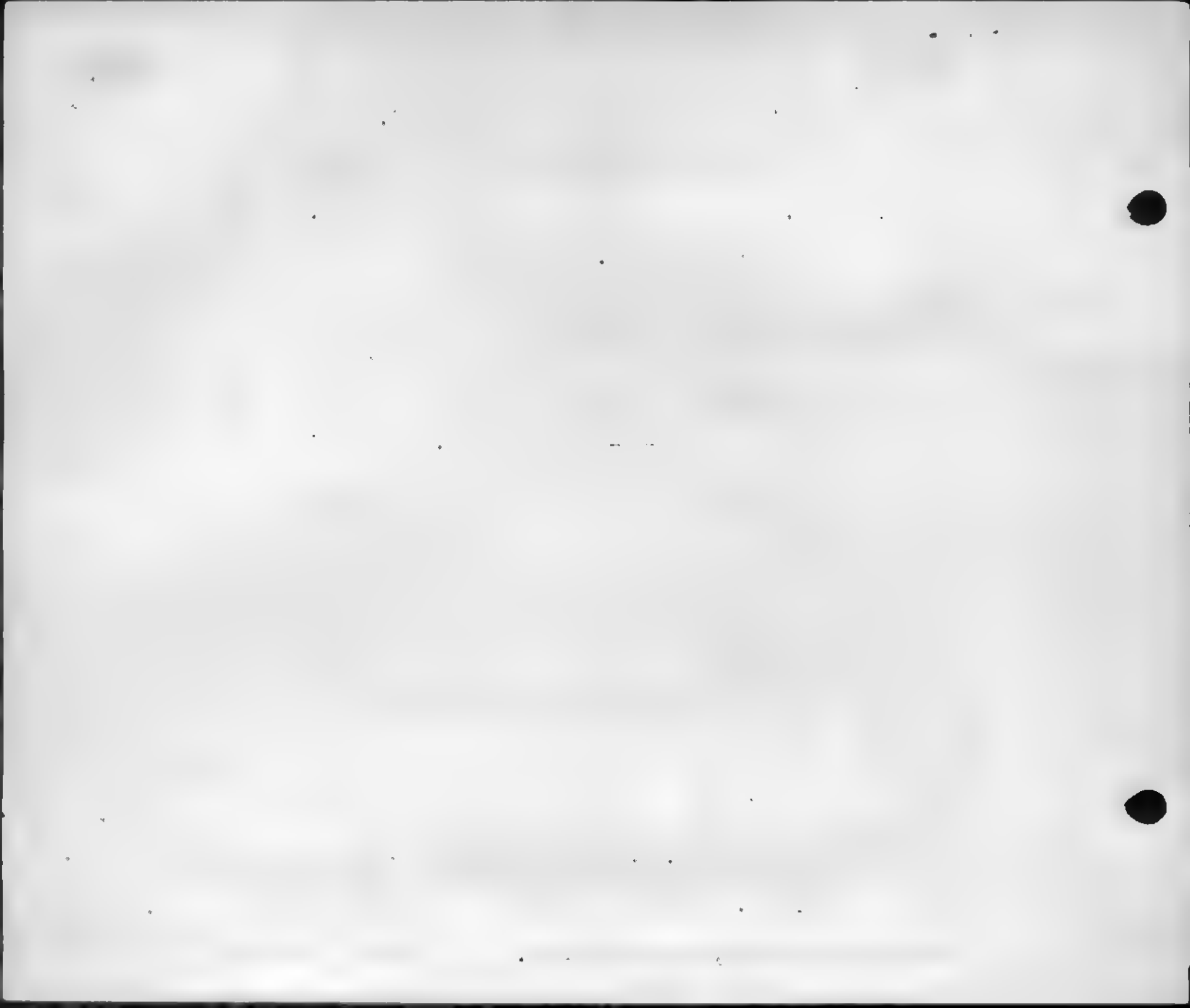
15115

CERTIFICATE OF DEATH

15115

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 132, Rte. 5</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Box 132, Rte. 5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mario V. Moscatelli</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8 May 1913</u> 9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>General Electric</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Rome, Italy</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1966</u>			
13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>019-10-2379</u> 17. INFORMANT <u>Lois F. Moscatelli, wife, same as 2</u> Address <u> </u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerotic Heart Disease</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>61</u> to <u>Nov 21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 7</u> , 19 <u>66</u> , and that death occurred at <u>1</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles Shaw, M. D.</u> M.D. 22b. ADDRESS <u>607 W. Joppa Road, Baltimore, Md.</u>				22c. PHYSICIAN'S NAME (Type) <u>Charles Shaw, M. D.</u> 22d. ADDRESS <u>607 W. Joppa Road, Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>23 Nov. 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Kirkley Funeral Home, Glen Burnie, Md.</u> ADDRESS <u> </u>			
25a. REC'D BY REGISTRAR <u>NOV 23 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

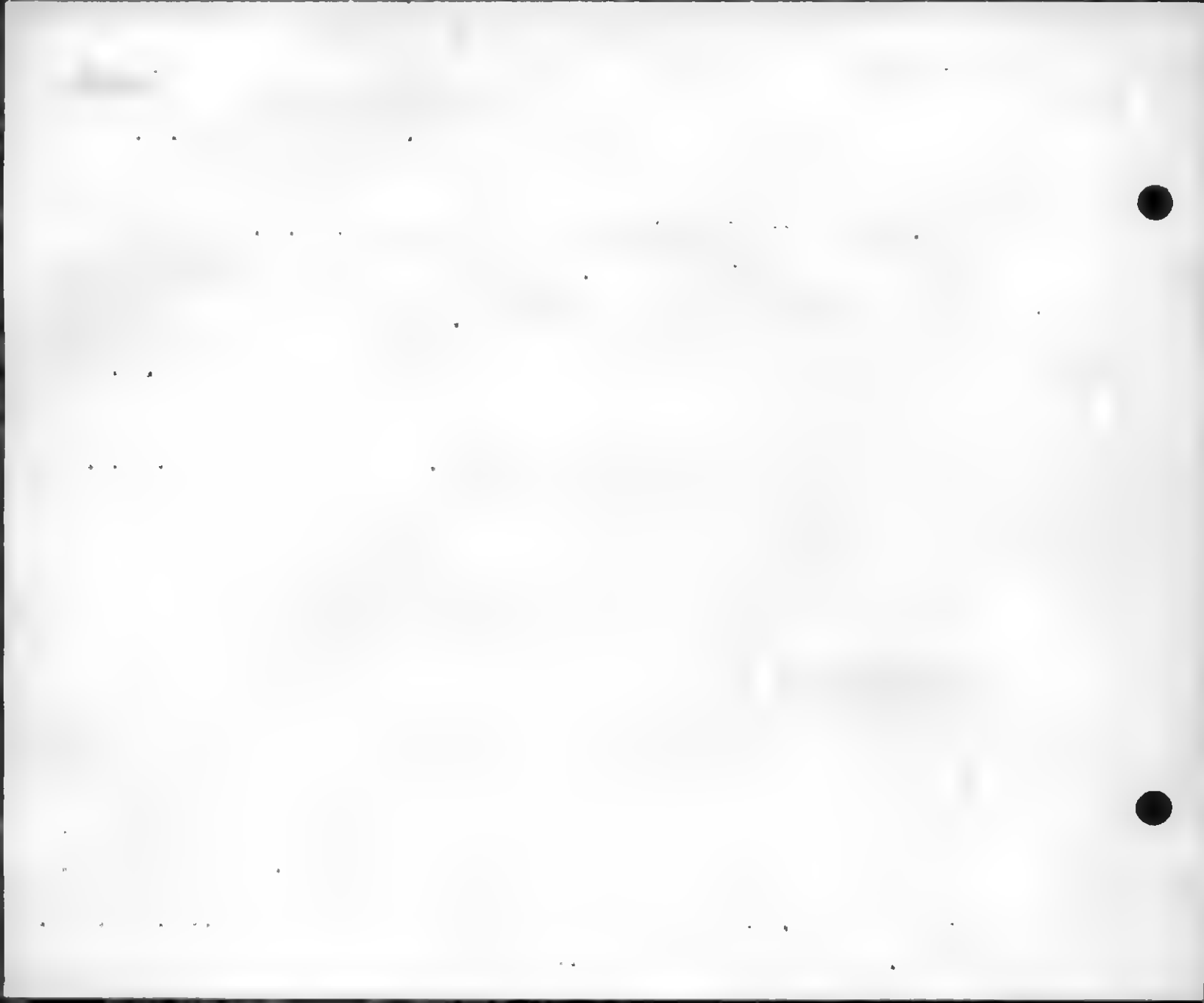
151116

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

151116

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY E. A.			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) N. Arundel General Hospital				d. STREET ADDRESS 8 Eighth Ave., N. W.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First AUGUSTA Middle G. Last MURR				4 DATE OF DEATH Month November Day 3 Year 1966			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 12, 1884		9 AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph Murr				14. MOTHER'S MAIDEN NAME Anna Schmidt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-0666		17. INFORMANT Jerome G. Wagner - 8 Eighth Ave., N.W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of Stomach - metastasized DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-3 , 19 66 to 11/3 , 19 66 that (I) (was) last saw the deceased alive on 11-3 19 66 , and that death occurred at 5:55 PM, from causes and on the date stated above.							
22a SIGNATURE Wayne B. Tate, M.D.				22b DATE SIGNED November 4, 1966		22c. PHYSICIAN'S NAME (Type) WAYNE B. Tate, M.D.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 7, 1966		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d LOCATION (City or Town) (County) (State) Ritchie Hwy., A.A.Co., Md.	
24 FUNERAL DIRECTOR George J. Gonce - 4001 Ritchie Hwy., Baltimore				25a. REC'D BY REGISTRAR DATE NOV 7 1966		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

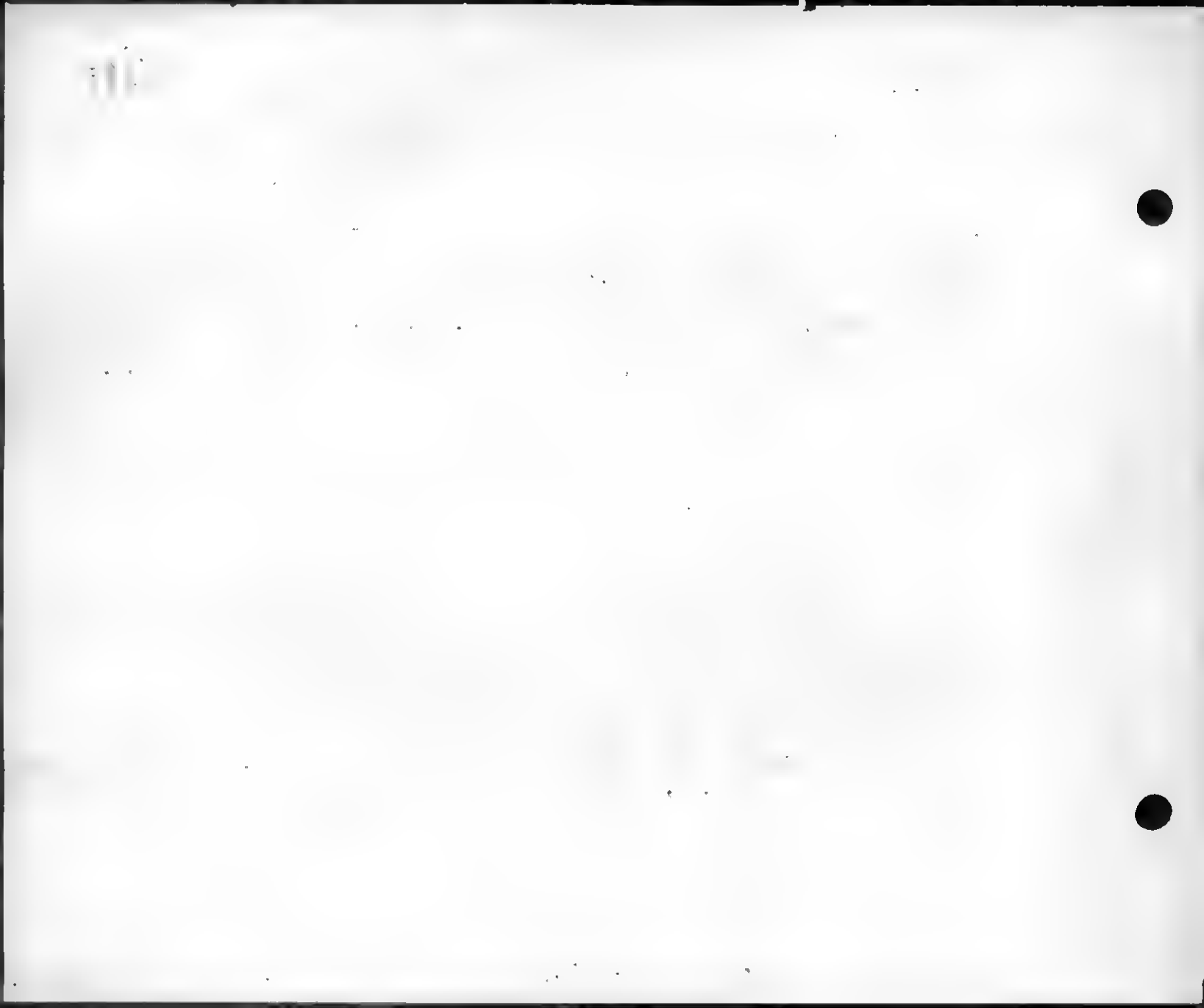
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15117

CERTIFICATE OF DEATH

15117

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Rt-1, Box-538		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Mae NALLEY				4. DATE OF DEATH Month Day Year November 1 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1882		9. AGE (In years last birthday) yrs. 84	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State or foreign country) MITCHELLVILLE Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE BEALL				14. MOTHER'S MAIDEN NAME LEVINIA ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO -		17. INFORMANT Address EDMUND F. NALLEY 1214 HART A. ACO MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Coronary occlusion DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from Nov. 1, 1966 , to Nov. 1, 1966 , that (I) (the doctor) last saw the deceased alive on Nov. 1, 1966 , and that death occurred at 11:40 AM , from causes and on the date stated above.							
22a. SIGNATURE Ray M. Smith				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/1/66	
22c. PHYSICIAN'S NAME (Type) RAY M. SMITH M.D.				22d. ADDRESS Severna Park Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-4-1966		23c. NAME OF CEMETERY OR CREMATORY WHITEMARSH CEM		23d. LOCATION (City or Town) (County) (State) PRI. GEORGETOWN MD.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD				25a. REC'D BY REGISTRAR NOV 4 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

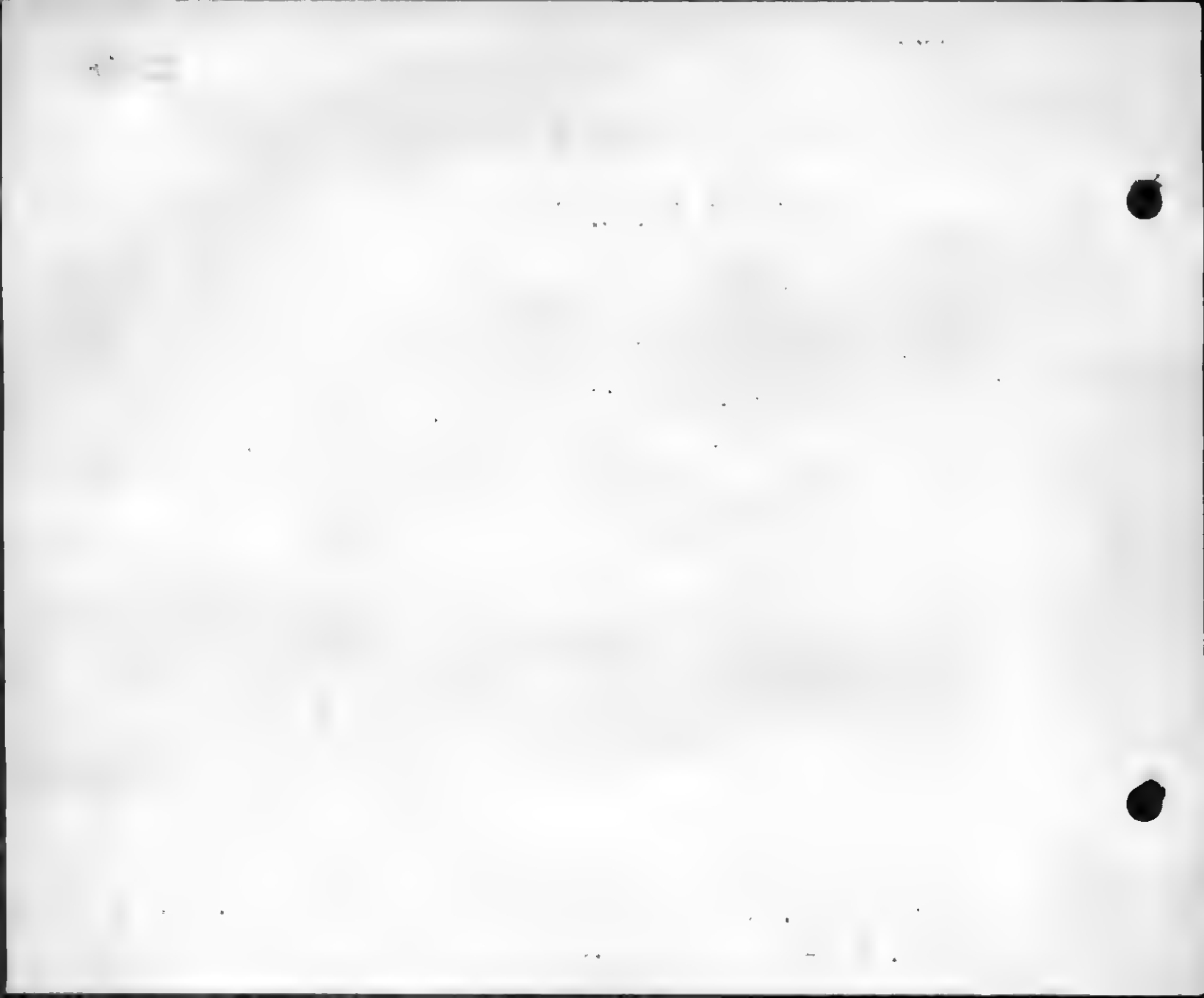
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15118

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15118

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Beach</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena, Md.</i>			
c. LENGTH OF STAY IN ID <i>7 years</i>				d. STREET ADDRESS <i>Riverside Drive</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Deer Creek Rt. 5, Box 233A, Pasadena, Md.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Henry</i> Last <i>Neff</i>				4. DATE OF DEATH Month <i>November</i> Day <i>17</i> Year <i>1966</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>October 25, 1906</i>	
9. AGE (In years last birthday) <i>66 yrs.</i>		IF UNDER 1 YEAR Months <i>11</i> Days <i>17</i> Hours <i>11</i> Min.		IF UNDER 24 HRS. Hours <i>11</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Business & holding Maryland license</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland license</i>			
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>			
13. FATHER'S NAME <i>Andrew Neff</i>				14. MOTHER'S MAIDEN NAME <i>Anna Fay</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>212-07-1716</i>			
17. INFORMANT <i>Mrs. James Neff</i>				Address <i>Pasadena, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the sept. lung</i> 163X DUE TO (b) <i>Pulmonary hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>none</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 year 20 minutes</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>September 15, 1966</i> to <i>Nov. 17, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov. 12, 1966</i> , and that death occurred at <i>11 A</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>R. M. McLaughlin</i>						22b. DATE SIGNED <i>11/17/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin, M.D.</i>						22d. ADDRESS <i>3718 Mountain Rd. Pasadena, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 21, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Ritchie Hwy., A.A. Co., Maryland</i>	
24. FUNERAL DIRECTOR <i>George J. Gonce-4001 Ritchie Hwy., Baltimore</i>				25a. REC'D BY REGISTRAR <i>NOV 23 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



CERTIFICATE OF DEATH

Reg. Dist. No.

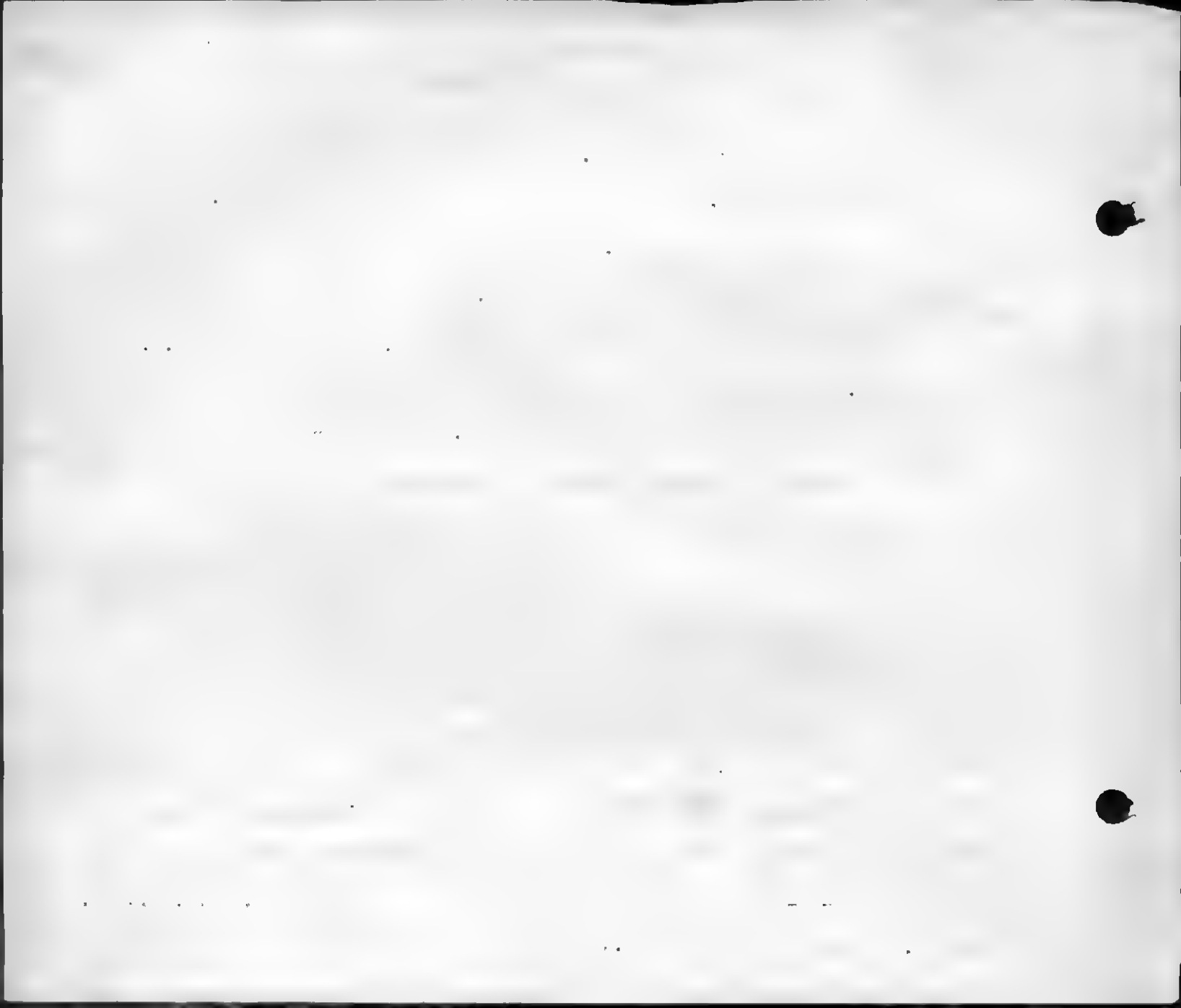
15119

15119

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE Maryland b COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Greenland Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenland Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 Greenland Beach Rd.		d STREET ADDRESS 202 Greenland Beach Rd.	
3 NAME OF DECEASED (Type or print) First ELEANOR Middle M. Last O'BROCKIE		4. DATE OF DEATH Month 11 Day 20 Year 1966	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 25, 1907
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John R. Stein		14 MOTHER'S MAIDEN NAME Katherine Patterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles J. O'Brockie - same		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MULTIPLE SCLEROSIS			
345 x DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/18, 1957 , to 11/20, 1966 , that I last saw the deceased alive on 11/11, 1966 , and that death occurred at 9:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Brady Smith		ADDRESS (Street, city or town, state) DATE SIGNED 8471 Ft. SMALLWOOD ROAD 11/21/66	
PHYSICIAN'S NAME (Type) J. BRADY SMITH		PASADENA, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-23-1966	22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	22d. LOCATION (City, town, or county) (State) Ritchie Hgwy., A.A.Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce-4001 Ritchie Hgwy., Baltimore		24a. REC'D BY REGISTRAR NOV 25 1966	
		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15120

CERTIFICATE OF DEATH

15120

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY in lb <u>12 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRACY'S LANDING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u>				d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>ELLEN</u> Middle <u>OWENS</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-1-91</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>ANNE ARUNDEL County</u>	
13. FATHER'S NAME <u>BROWN JOHN</u>				14. MOTHER'S MAIDEN NAME <u>ANNE CONWAY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>-</u>		17. INFORMANT <u>WILLIAM B. OWENS, Son</u> Address <u>Harwood</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>TERMINAL STAGE LEIOMYOSARCOMA, RETRO PERITONEAL</u> DUE TO (c) <u>SPACE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASCITES, ANEMIA, ASHD Chronic Urinary tract infection</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-1</u> , 19 <u>66</u> , to <u>11-12</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>11-12</u> 19 <u>66</u> and that death occurred at <u>9:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Martin T. Kim</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARTIN T. KIM, M.D.</u>				22d. ADDRESS <u>SHADY SIDE, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Tracy's AA Md</u>	
24. FUNERAL DIRECTOR <u>Anthony E. Sewell, Prince Frederick</u>				ADDRESS <u>Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 17 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

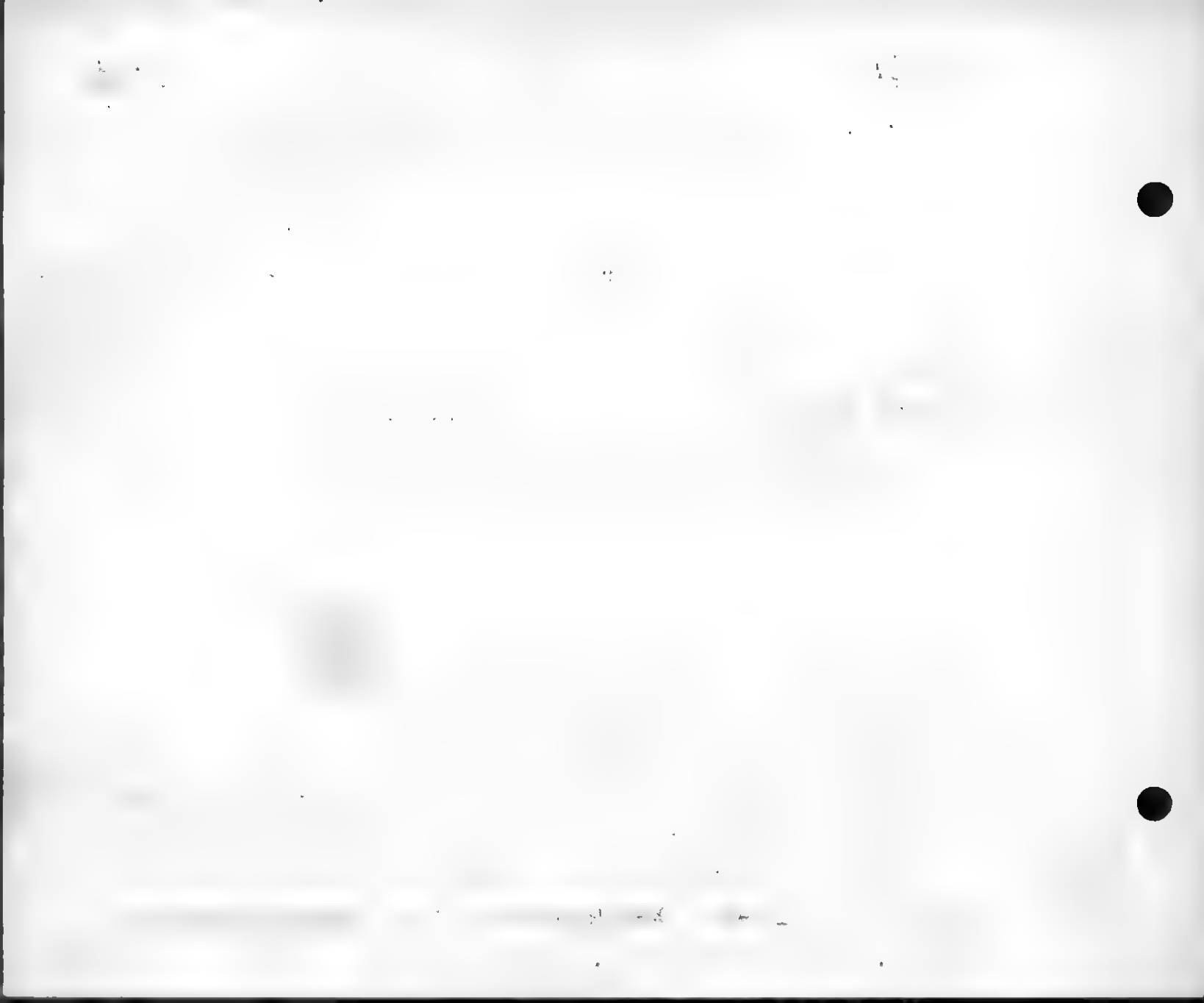
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15121

CERTIFICATE OF DEATH

15121

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Box 246 B, Rt. 9	
3 NAME OF DECEASED (Type or print) Eleanor Miller PEARMAN		4 DATE OF DEATH Month November Day 6 Year 1966	
5. SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 5, 1897
9 AGE (in years last birthday) 69 yrs		IF UNDER 1 YEAR Months 11 Days 1 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Richard Miller		14. MOTHER'S MAIDEN NAME Clara Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT Bertha Fisher Boy 246 B Rt 9		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO Arteriosclerotic Heart Disease DUE TO Hypertension DUE TO 4200		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/9, 1963 , to 11/6, 1966 , that (I) (we) last saw the deceased alive on 4/6, 1966 , and that death occurred at 9:10 P.M. from causes and on the date stated above.		22b. DATE SIGNED 11/7/66	
22a. SIGNATURE Richard I. Hochman, M.D.		22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.	
22d. ADDRESS 59 Franklin St. Annapolis, Md		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-10-66	23c. NAME OF CEMETERY OR CREMATORY Walt's Monchuch Yard	23d. LOCATION (City or Town) (County) (State) Pasadena Anne Arundel Md
24 FUNERAL DIRECTOR Isaiah L. Brown and Son-108-W. Montgomery		25a. REG'D BY REG. SEC. NOV 15 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15122

CERTIFICATE OF DEATH

15122

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>////</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d STREET ADDRESS <u>#105 Chestnut Lane N/W</u>	
3 NAME OF DECEASED (Type or print) <u>Lucy Louise Petticrew</u>		4 DATE OF DEATH <u>November 21, 19 66</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 6, 1912</u>
9 AGE (In years last birthday) <u>54</u> yrs		F UNDER 1 YEAR <u> </u> Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Walter Huffman</u>		14. MOTHER'S MAIDEN NAME <u>Lulu Heaton</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>301-09-9170</u>	
17 INFORMANT <u>Mr. James M. Petticrew (Husband)</u>		Address <u>Same as #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>43-44</u> IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Chronic Myocardial Failure</u> DUE TO (c) <u>Cor Pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>3 yul</u> <u>5 yul</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-24</u> , 19 <u>66</u> to <u>11-21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-19</u> , 19 <u>66</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>M.W. Jacobson</u>		22b. DATE SIGNED <u>11-22-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.W. JACOBSON M.D.</u>		22d. ADDRESS <u>6821 Reisterstown Rd Ball 18</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 25, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ferncliff Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Springfield Ohio</u>	
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>		25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 23 1966</u>	

61

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

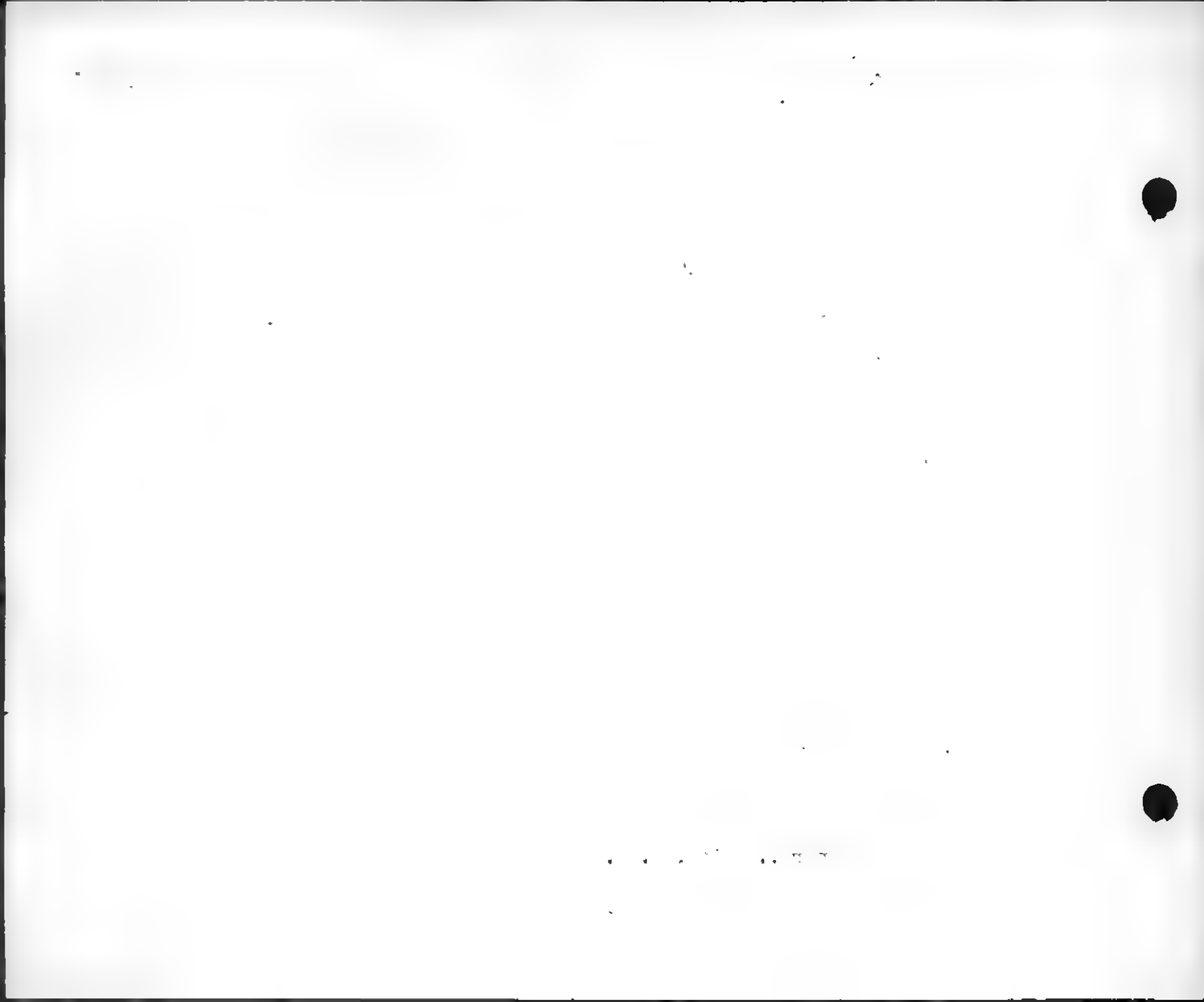
VR A15ME (5)
6M 1/66

15123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15123

1 PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ferndale</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>North Arundel Hospital</i>		d. STREET ADDRESS <i>311 Columbus Road</i>	
3 NAME OF DECEASED (Type or print) <i>Raymond</i> First Middle Last <i>PITTS</i>		4 DATE OF DEATH Month <i>Nov.</i> Day <i>7</i> Year <i>1966</i>	
5 SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/27/37</i>
9 AGE (In years last birthday) <i>29</i> yrs		10. F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JAMES PITTS</i>		14. MOTHER'S MAIDEN NAME <i>ANNIE</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes</i>		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Mrs Rose Pitts</i>		Address <i>311 Columbus Rd</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HANGING</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Hung self in Jail cell of Ferndale police station</i>	
20c. TIME OF INJURY Month, Day, Year <i>6:00 PM 11/7/1966</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Jail</i>	20f. (City or town) (County) (State) <i>Ferndale AA MD.</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D.		22. DATE SIGNED <i>Nov 8th 1966</i>	
EXAMINER'S NAME (Type) <i>Werner U. Spitz, M.D.</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11/11/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt CALVARY</i>	23d. LOCATION (City or Town) (County) (State) <i>AA COUNTY MD</i>
24. FUNERAL DIRECTOR <i>ADOLPHUS HALSTEAD</i>		ADDRESS <i>1206 W North Ave</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 14 1966</i>
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

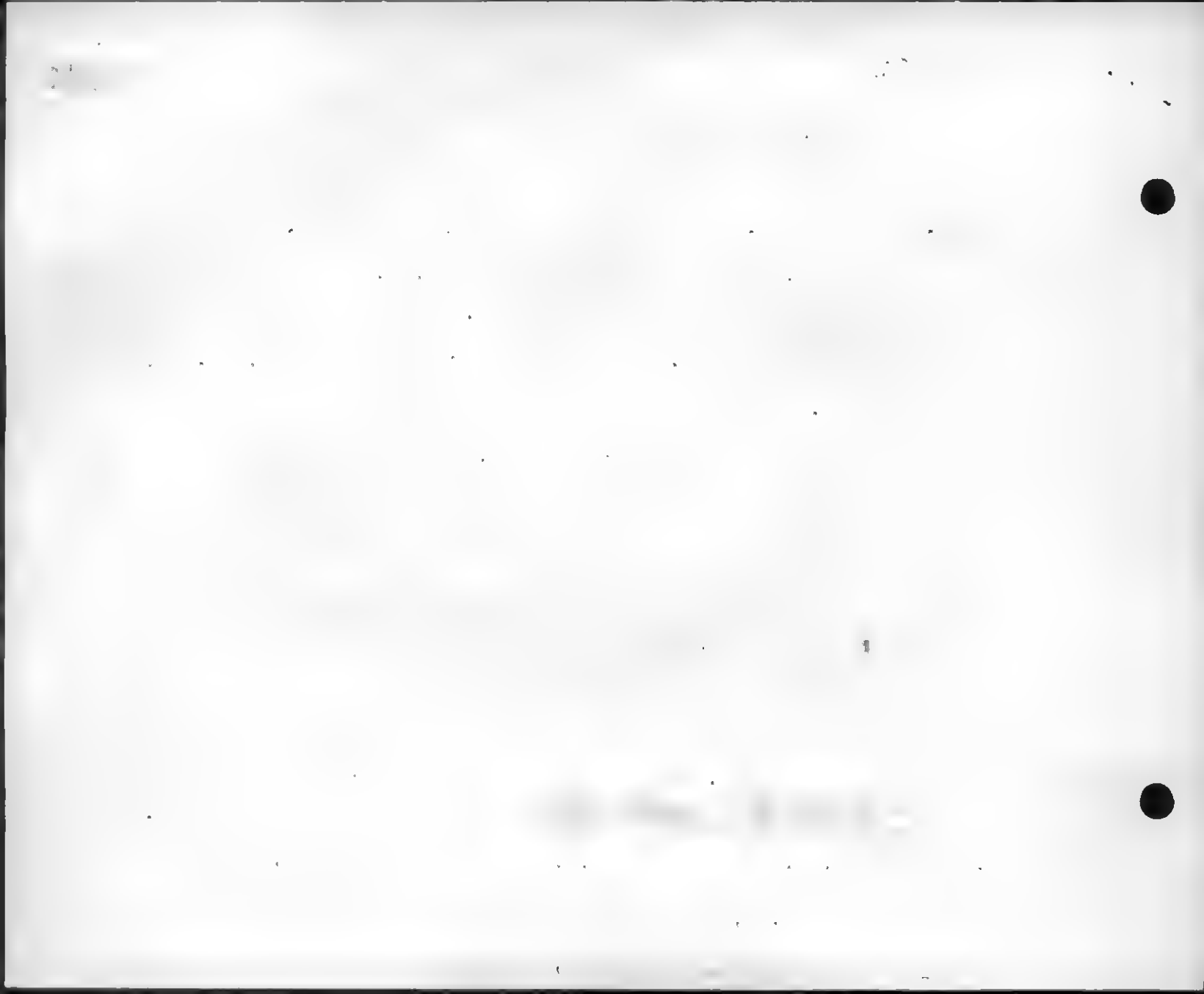
15124

CERTIFICATE OF DEATH

15124

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN TB <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>N. Arundel Hosp.</u>				d. STREET ADDRESS <u>Brookwood Rd.</u>			
3 NAME OF DECEASED (Type or print) <u>William Floyd Price, Sr.</u>				4 DATE OF DEATH <u>November 6, 1966</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1905</u>	9 AGE (n years last birthday) <u>60 yrs</u>	10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Nat'l Bank</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Berkeley Springs W. Va.</u>			
13 FATHER'S NAME <u>William L. Price</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Gibbs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>214-05-4194</u>		17 INFORMANT <u>Mrs. Gayle Price (wife) Same As #2</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic Carcinoma of Rectum</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>63</u> , to <u>November</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov. 6,</u> 19 <u>66</u> , and that death occurred at <u>2:13 PM</u> from causes and on the date stated above							
22a. SIGNATURE <u>C. R. Mac Donald M.D.</u>				22b. DATE SIGNED <u>Nov. 7, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. R. Mac Donald M.D.</u>				22d. ADDRESS <u>204 Crain Hwy. S/W Glen Burnie, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 9, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>			
23d. LOCATION (City or Town) <u>Cumberland, Maryland</u>		(County) (State)					
24 FUNERAL DIRECTOR <u>Eugene B. Thacker</u>		25a. REC'D BY REGISTRAR <u>DATE NOV 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

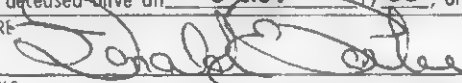
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15125

CERTIFICATE OF DEATH

15125

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE			c. LENGTH OF STAY IN 1b 5 HOURS	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ODENTON			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				d STREET ADDRESS RT 1 BOX 307 BUCKLINA		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First CALLISTA Middle V Last PROSEY				4 DATE OF DEATH Month NOVEMBER Day 8 Year 19 66			
5 SEX FEMALE	6 COLOR OR RACE CAU	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 25 DEC 14		9 AGE (In years last birthday) yrs 51	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY -		11 BIRTHPLACE (County & State or foreign country) BALTIMORE MD		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EARL FRANTON				14. MOTHER'S MAIDEN NAME CALLISTA FITSPATRICK			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 218-18-4611 UNKNOWN		17. INFORMANT Address JACK D PROSEY SAME AS 2D			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LUNG 1 / 0 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BREAST CARCINOMA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS 3 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 NOV , 19 66 , to 8 NOV , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8 NOV , 19 66 , and that death occurred at 1105 PM , from causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9 NOV 66	
22c. PHYSICIAN'S NAME (Type) DONALD E PARLEE, CAPT, MD				22d. ADDRESS KIMBROUGH ARMY HOSPITAL			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 11, 1966		23c. NAME OF CEMETERY OR CREMATORY Epiphany Episcopal Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Odenton A.A. Md.	
24. FUNERAL DIRECTOR Beverley E. Hopping, HOPPING FUNERAL HOME				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

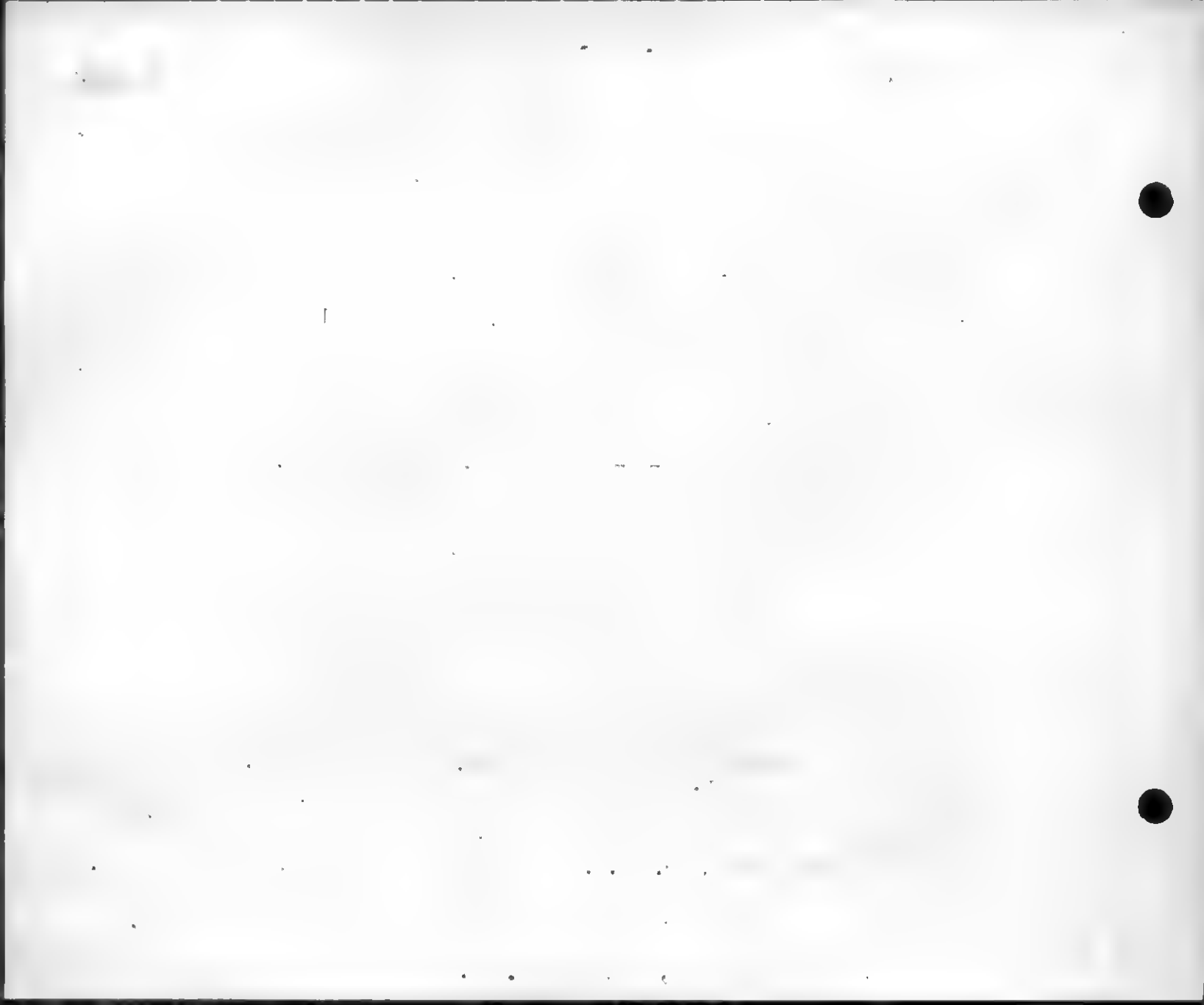
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15126

CERTIFICATE OF DEATH

15126

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Rt. 1, Box 66B		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Michael Paul RASPA				4. DATE OF DEATH Month Day Year November 8 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 23, 1921		9. AGE (In years last birthday) 45 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing & Heating		11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank Rampa				14. MOTHER'S MAIDEN NAME Angelin Montiferenti			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 216-12-3439		17. INFORMANT Address Mrs. Gertrude Raspa, same as 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal Tubular Necrosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Oct. 23,</u> 19 <u>66</u> to <u>Nov. 8,</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov. 8</u> 19 <u>66</u> , and that death occurred at <u>5:30 P.M.</u> M. from causes and on the date stated above.							
22a. SIGNATURE <i>Edwin Davis, Jr.</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11/9/66			
22c. PHYSICIAN'S NAME (Type) Edwin Davis, Jr. M.D.		22d. ADDRESS 100 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12 Nov. 1966		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.				25a. REC'D BY REGISTRAR DATE NOV 14 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15127

CERTIFICATE OF DEATH

15127

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE		c. LENGTH OF STAY in 1b 10 hrs 54 min	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G. MEADE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL			d. STREET ADDRESS 7229-F HALL STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MICHAEL I TYBONE RIVERS First Middle Last			4. DATE OF DEATH NOV 2 19 66 Month Day Year		
5. SEX MALE	6. CO. OR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 NOVEMBER 66		9. AGE (In years lost birthday) yrs. 10 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State or foreign country) ANNE ARUNDEL, MARYLAND		12. C. TIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WALTER RIVERS			14. MOTHER'S MAIDEN NAME MARVA COOPER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO N/A	17. INFORMANT WALTER RIVERS Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress Syndrome DUE TO (b) Associated c prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH < 12 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7:30 PM , 19 66 , to 11 PM , 19 66 , that (I) (we) last saw the deceased alive on 2 Nov 19 66 , and that death occurred at 10:55 PM , from causes and on the date stated above.					
22a. SIGNATURE Robert F. Cullen Jr.			22b. DATE SIGNED 3 Nov. 66		
22c. PHYSICIAN'S NAME (Type) ROBERT F. CULLEN, CPT, MC			22d. ADDRESS Kimbrough Army Hosp, Ft Geo G. Meade, Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 7, 1966	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA		
24. FUNERAL DIRECTOR Harold S. Wade		25a. REC'D BY REGISTRAR 550 1st St Bldg Laurel, Md	25b. REGISTRAR'S SIGNATURE James		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15128

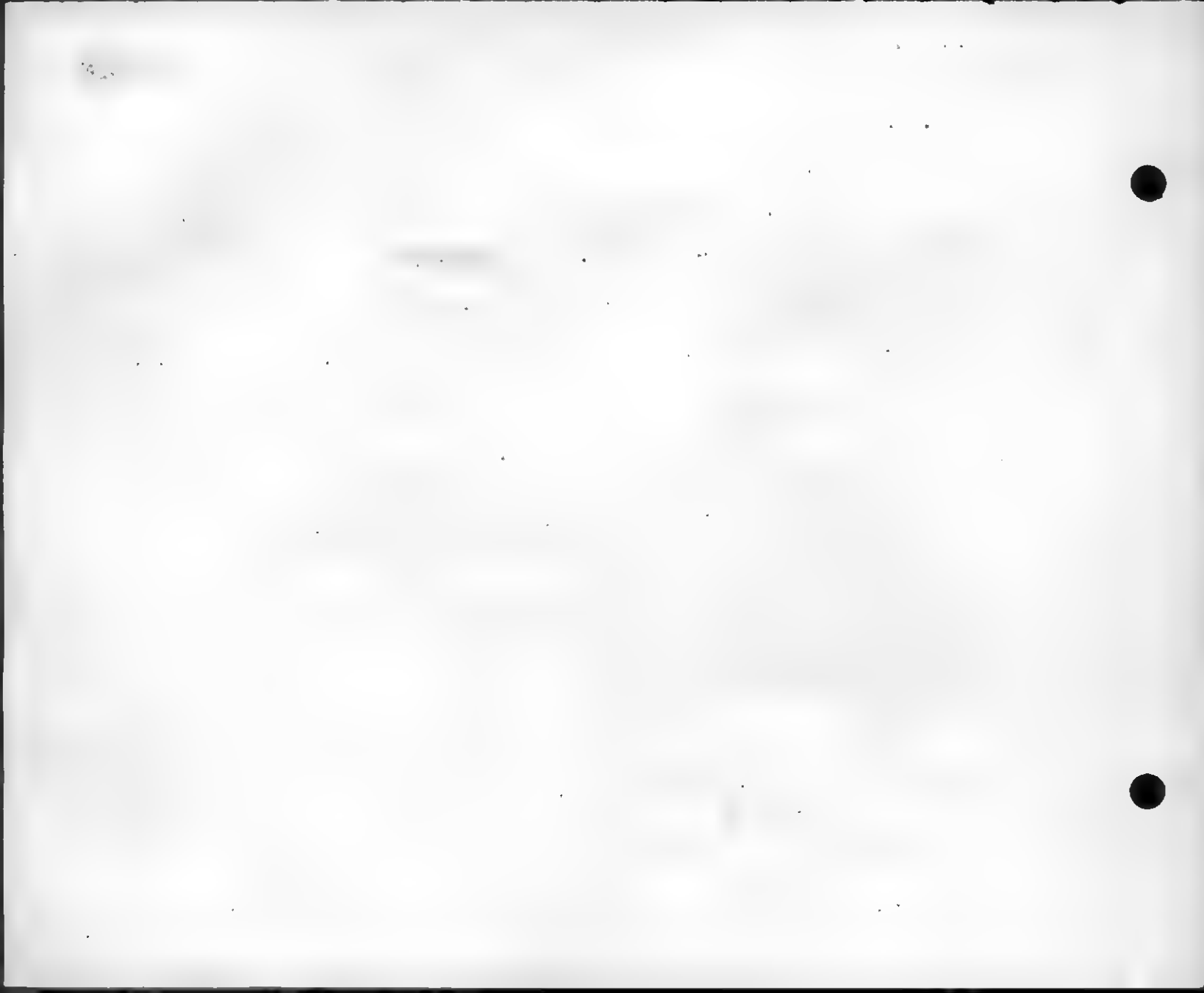
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15128

1. PLACE OF DEATH a. COUNTY A. A. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3523 Chesterfield Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Thelma M. Robertson		4. DATE OF DEATH Month November Day 18, Year 19 66						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1926	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months 40	IF UNDER 24 HRS. Days 18	Hours 18	Min. 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lawrence Smith				14. MOTHER'S MAIDEN NAME Ethel Watson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Marlan Robertson		Address as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Severe Asthma - Cx - Pulmoe. - DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11/9 , 19 66 , to 11/18 , 19 66 , that (I) (we) last saw the deceased alive on 11/16 , 19 66 , and that death occurred at 11/18 M, from the causes and on the date stated above.								
22a. SIGNATURE [Signature]				22b. DATE SIGNED 11/19/66		22c. PHYSICIAN'S NAME (Type) DRE. M. RAMOS		
22d. ADDRESS 3927 Annapolis Rd -								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/66		23c. NAME OF CEMETERY OR CREMATORY Moreland memorial		23d. LOCATION (City, town or county) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR William J. Dickner & Sons				25a. REC'D BY REGISTRAR NOV 21 1966		25b. REGISTRAR'S SIGNATURE [Signature]		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15129

CERTIFICATE OF DEATH

15129

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BOX 148, Route #1		d. STREET ADDRESS BOX 148, Route #1	
3. NAME OF DECEASED (Type or print) First JOHN Middle (NMI) Last ROMANOS		4. DATE OF DEATH Month NOVEMBER Day 12 Year 19 66	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 AUG 1888
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Law	
11. BIRTHPLACE (County & State, or foreign country) Taganrog, Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irines Romanos		14. MOTHER'S MAIDEN NAME Sotisa Hazardji	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. 217-56-3481	
17. INFORMANT Mrs. Xenia M. Jelich, Box 148, Route #1		Address Crownsville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probably, acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XXXXXX the deceased XXXX WAS DOA XXXX 12 NOV 1966 , and that death occurred at 8:15 from causes and on the date stated above.			
22a. SIGNATURE Neil A. Robinson		22b. DATE SIGNED 12 NOV 66	
22c. PHYSICIAN'S NAME (Type) NEIL A. ROBINSON, CPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Nov. 15, 1966	23c. NAME OF CEMETERY OR CREMATORY St. Stephens Church Cemetery, Millersville, Maryland	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REGISTRAR NOV 15 1966	
		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

W

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

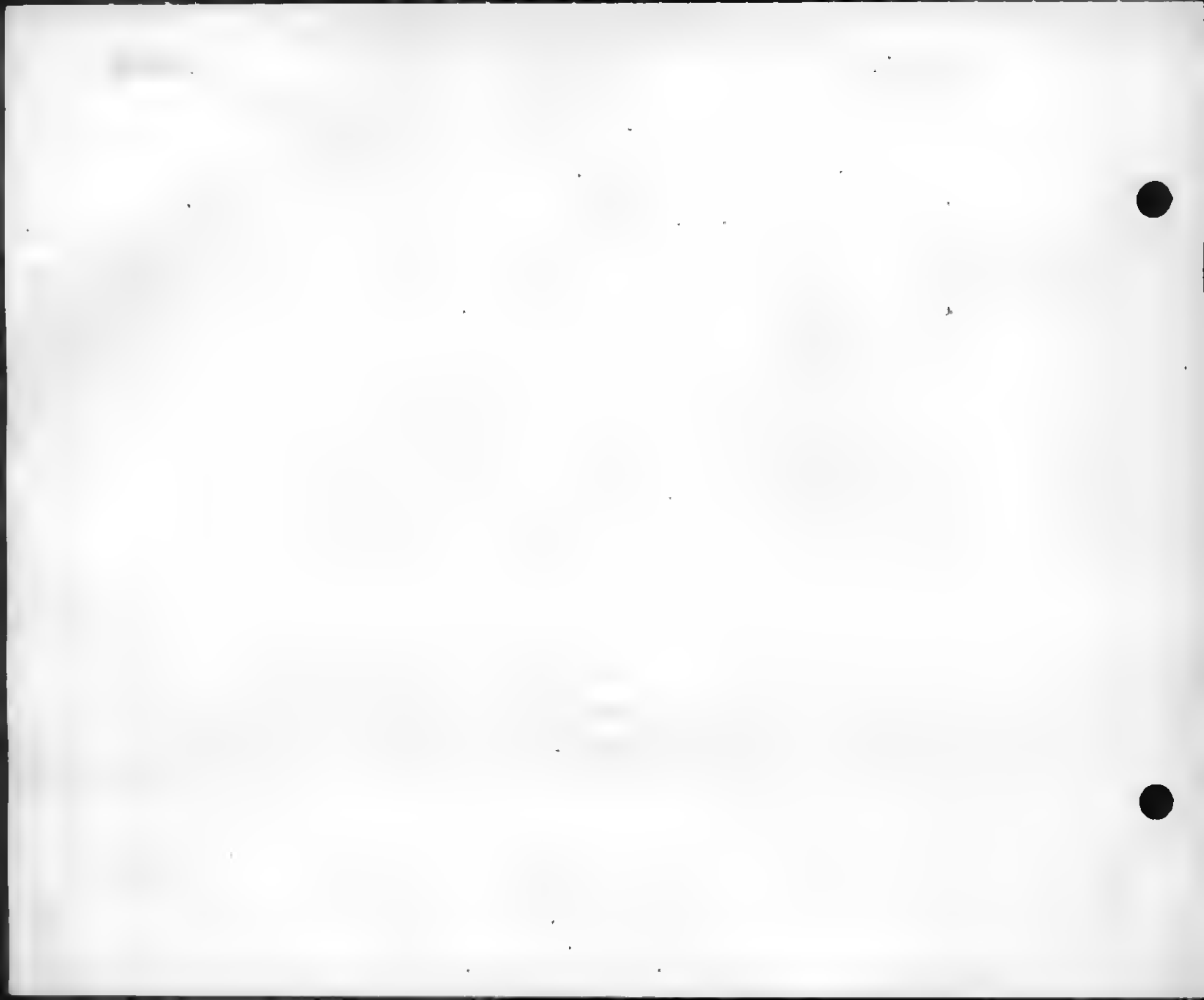
15130

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16584

1 PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <i>Ohio</i> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c LENGTH OF STAY IN 1b <i>3 mths</i>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cleveland</i>		7x 5	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Crownsville State Hosp.</i>		d STREET ADDRESS <i>819 Eddy Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <i>Abe</i> Middle Last <i>Sacheroff</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>27th</i> Year <i>1966</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>10/10/97</i>
9 AGE (In years last birthday) <i>69</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12 CITIZEN OF WHAT COUNTRY? <i>U S</i>	
13. FATHER'S NAME <i>Max Sacheroff</i>		14. MOTHER'S MAIDEN NAME <i>Mollie</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Phlebotomy of lower extremities</i> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8/16</i> , 1966, to <i>11/27</i> , 1966, that (I) (we) last saw the deceased alive on <i>11/27</i> , 1966, and that death occurred at <i>4:45 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Atvin Thompson</i> M.D.		22b. DATE SIGNED <i>11/27/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Atvin Thompson</i>		22d. ADDRESS <i>Crownsville State Hospital</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE THEREOF <i>12/26/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>UNIVERSITY MD</i>	23d. LOCATION (City or Town) (County) (State) <i>BAIT, MD</i>
24. FUNERAL DIRECTOR <i>William Reese II</i> Address <i>Annapolis, Maryland</i>		25a. REC'D BY REGISTRAR <i>DEC 22 1966</i>	
		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

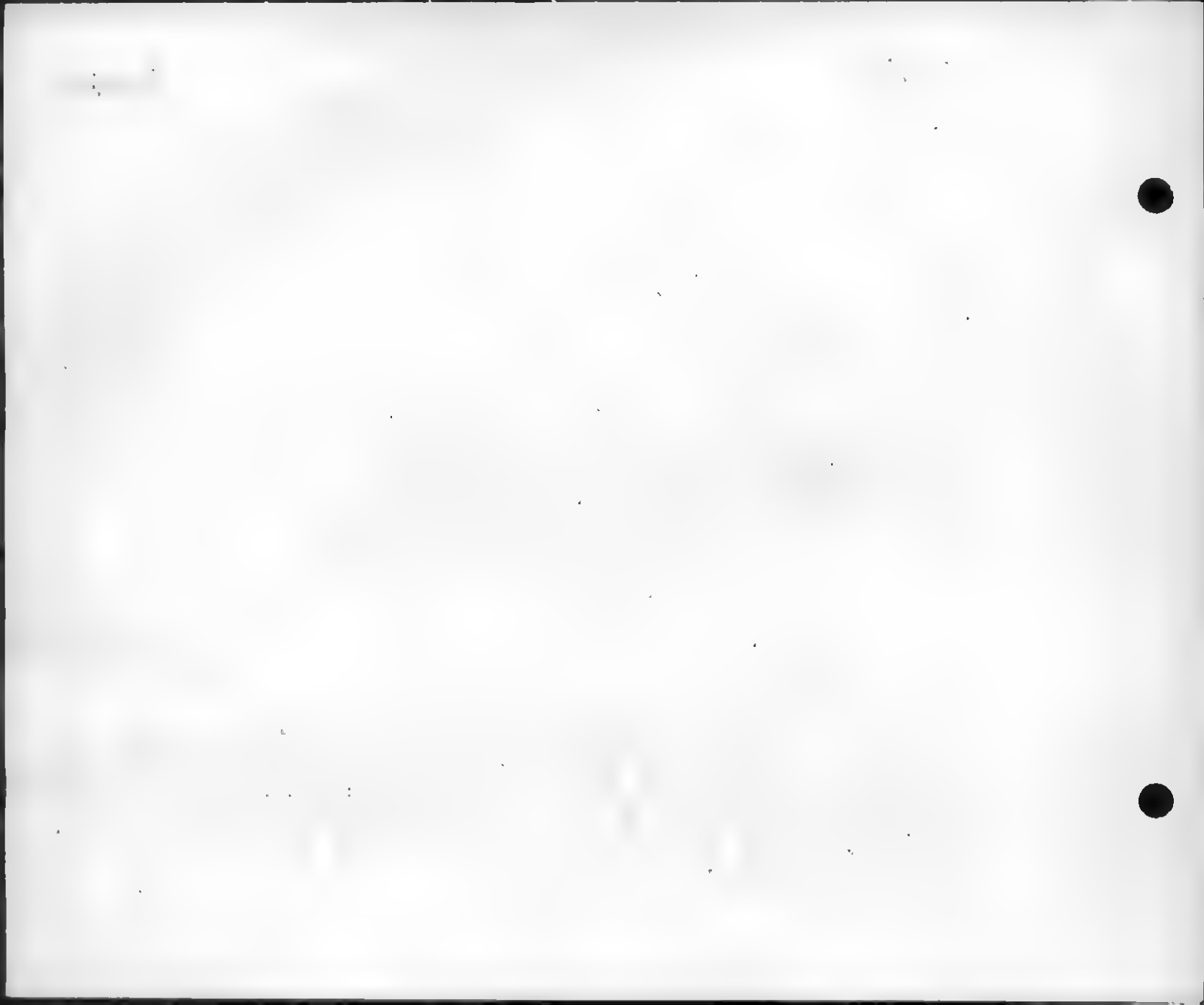
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15131

CERTIFICATE OF DEATH

15130

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Richard Thomas SCOTT</u>		4 DATE OF DEATH Month Day Year <u>November 30 1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 22, 1892</u>
9 AGE (In years birth day) yrs <u>73</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13 FATHER'S NAME <u>Richard Scott</u>		14 MOTHER'S MAIDEN NAME <u>Georgette Myer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u>		16 SOCIAL SECURITY NO <u>218465331</u>	
17 INFORMANT <u>Rachel Wicks Shadyside</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO (b) <u>Cerebral thrombosis & rt. hemiplegia & aphasia</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>1962 Pulmonary tuberculosis, arrested</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>Nov. 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov. 29, 1966</u> , and that death occurred at <u>(9:30 A.M.)</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u>		22b. DATE SIGNED <u>11/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith, MD</u>		22d. ADDRESS <u>Shady Side, Md.</u>	
23a. BURIAL, CREMATION, REMOVA (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-3-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews</u>		23d. LOCATION (City or Town) (County) (State) <u>Shady Side Md</u>	
24. FUNERAL DIRECTOR <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 2 1966</u>	



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.)

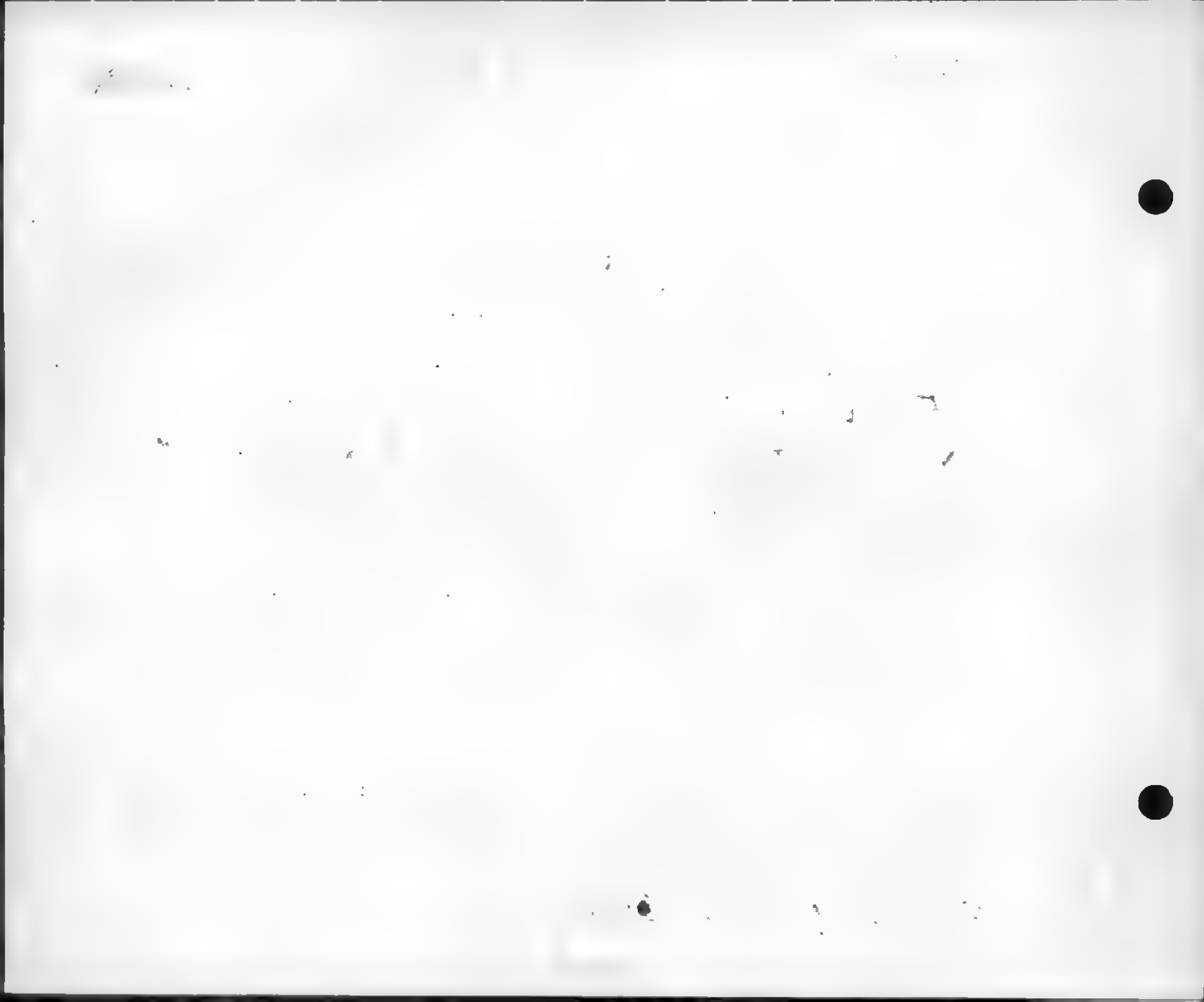
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15132

CERTIFICATE OF DEATH

15131

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hbospital				d. STREET ADDRESS 826 Boucher Ave.			
3. NAME OF DECEASED (Type or print) William B. SEGELKEN				4. DATE OF DEATH November 12 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 21, 1897	9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE USMEL		10b. KIND OF BUSINESS OR INDUSTRY USMEL		11. BIRTHPLACE (County & State, or foreign country) Annapolis MD.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME FREDERICK SEGELKEN				14. MOTHER'S MAIDEN NAME Mary E. Vogt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. WW I		17. INFORMANT MARTHA E. SEGELKEN #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Acute Pulmonary Edema DUE TO (c) Myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 3 wks 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) B.P.H.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan, 1963 , to 11-12, 1966 , that (I) (we) last saw the deceased alive on 11-16, 1966 , and that death occurred at 12:15 A.M. from causes and on the date stated above.							
22a. SIGNATURE Frank M. Shipley				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-12-66	
22c. PHYSICIAN'S NAME (Type) F M SHIPLEY				22d. ADDRESS Annapolis, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-15-66		23c. NAME OF CEMETERY OR CREMATORY CEDAR Bury		23d. LOCATION (City or Town) (County) (State) Annapolis H.A. MD.	
24. FUNERAL DIRECTOR John M. Fyfe & Sons Annapolis, Md				25a. REC'D BY REGISTRAR DATE NOV 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15133

CERTIFICATE OF DEATH

15132

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE Maryland b COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 29 Shaw St.,			
3. NAME OF DECEASED (Type or print) First Anna Middle Marie Last SHARPS				e. DATE OF DEATH Month November Day 15 Year 19 66			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1924	9. AGE (In years last birthday) yrs. 42	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Samuel Owens				14. MOTHER'S MAIDEN NAME Marie Hall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Nathaniel Franklin Address 24 Shaw St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Mitral valve insufficiency DUE TO (c) Rheumatic fever (?)							INTERVAL BETWEEN ONSET AND DEATH 6 months 7 years unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension, diabetes mellitus, diabetic nephrosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the doctor) attended the deceased from 18 Feb. , 19 66 , to 15 Nov. , 19 66 , that (I) (we) last saw the deceased alive on 8 Nov. , 19 66 , and that death occurred at 7:50 AM , from causes and on the date stated above.							
22a. SIGNATURE Charles W. Kinzer			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 16 Nov. 1966	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M.D.			22d. ADDRESS SouthRivMedCent., Edgewater, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Buried		11-18-1966	Mount Pleasant		Wesley		
24. FUNERAL DIRECTOR William Reese			ADDRESS Curran Rd.		25a. REC'D BY REGISTRAR Charles Judge		
					25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15134

15133

1. PLACE OF DEATH a. COUNTY <u>DC</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>2 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>PENNA</u> b. COUNTY <u>LANCASTER</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EAST EARL R.D. 1</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hector</u> <u>Smith</u> First Middle Last		4. DATE OF DEATH <u>Nov 1</u> 19 <u>66</u> Month Day Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 5 1876</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>GOLF</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Smith</u> 14. MOTHER'S MAIDEN NAME <u>JEAN PETERSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> 16. SOCIAL SECURITY NO. <u>168-01-9906</u> 17. INFORMANT <u>Miss Lucy H. H. 15 Cornhill St., Annapolis, Md</u> Address		18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Arteriosclerosis</u> (c) <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10-27</u>, 19<u>66</u>, to <u>11-1</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>10-31</u>, 19<u>66</u>, and that death occurred at <u>6:00 PM</u>, from the causes and on the date stated above.			
22a. SIGNATURE <u>W. P. Stephens</u> 22c. PHYSICIAN'S NAME (Type) <u>W. P. STEPHENS</u>		22b. DATE SIGNED <u>11-1-66</u> 22d. ADDRESS <u>Annapolis Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>Nov 4, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove</u> 23d. LOCATION (City, town or county) (State) <u>EAST EARL, PENN</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Hardisty, Annapolis, Md</u> ADDRESS	
25a. REC'D BY REGISTRAR DATE <u>NOV 3</u> 19 <u>66</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15135

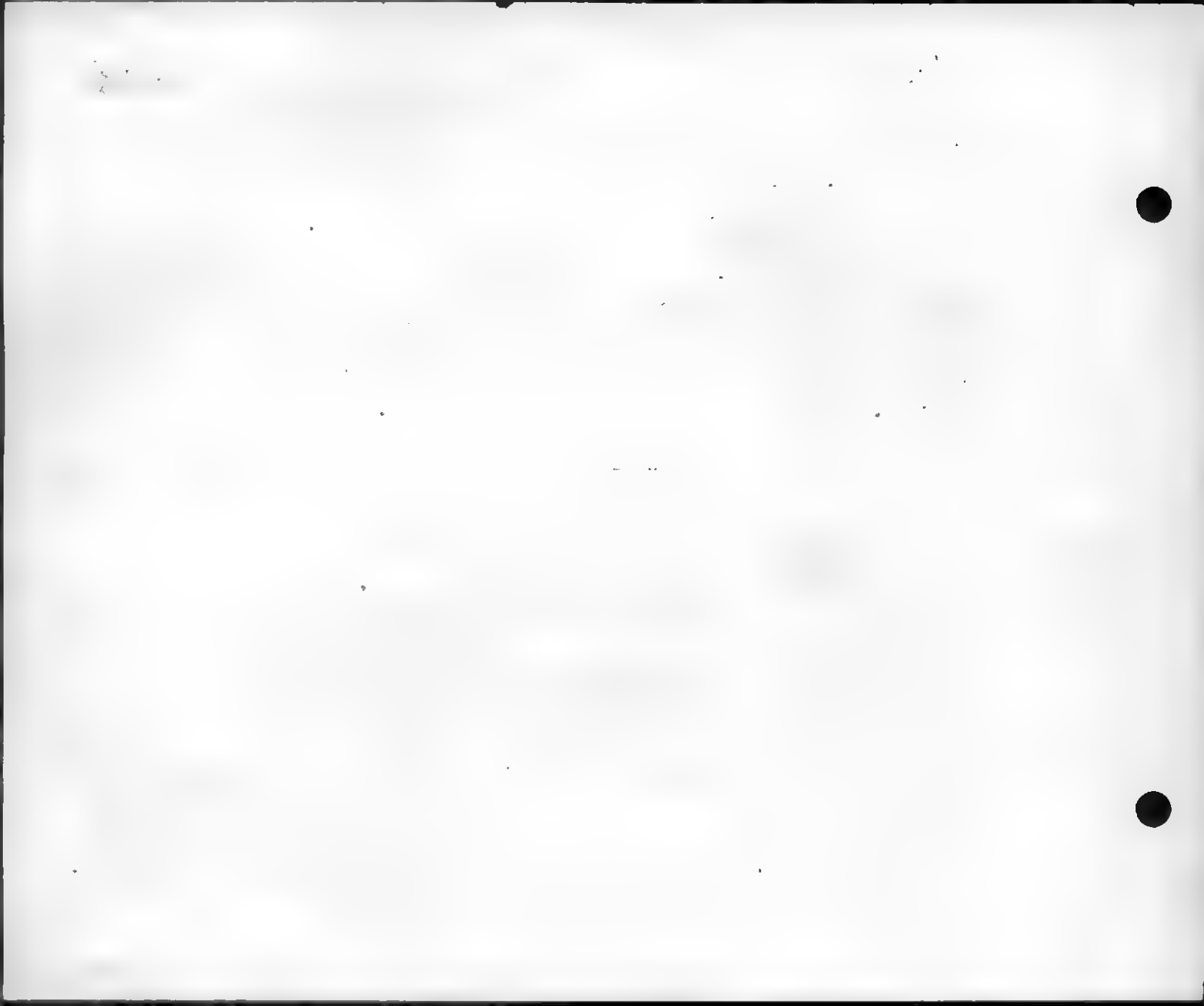
CERTIFICATE OF DEATH

15134

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Fort George G. Meade		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kimbrough Army Hospital		d. STREET ADDRESS 98 Waterbury Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) IRENE JONES SMITH		4 DATE OF DEATH Month November Day 5 Year 1966	
5 SEX Female	6 COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 June 1920 9 AGE (In years last birthday) yrs 46
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital	11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James H. Jones		14. MOTHER'S MAIDEN NAME Mary C. Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No n/a		16. SOCIAL SECURITY NO. 213-22-2244	17. INFORMANT Jim Smith (Husband) Address Crownsville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion DUE TO (b) Advanced Metastatic Cancer DUE TO (c) Cancer of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 1959-Pres.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Not Applicable	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 14 October, 1966 to 5 November 1966 , that XX (we) last saw the deceased alive on 5 November 1966 , and that death occurred at 03:30 , from causes and on the date stated above.			
22a. SIGNATURE <i>Burton A. Johnson, Capt MC</i> MD		22b. DATE SIGNED 5 November 1966	22c. PHYSICIAN'S NAME (Type) BURTON A. JOHNSON, CAPT, MC
22d. ADDRESS KIMBROUGH ARMY HOSPITAL, FCGM, MD.			
23a. BURIAL, CREMATION OR REMOVAL (Specify)	23b. DATE THEREOF 11-8-1966	23c. NAME OF CEMETERY OR CREMATORY Fort Meade	23d. LOCATION (City or Town) (County) (State) Waterbury Md
24. FUNERAL DIRECTOR <i>Reese Fennell Rose</i>		25a. REC'D BY REGISTRAR NOV 7 1966	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15135											
1. PLACE OF DEATH a. COUNTY <u>J. A. Co</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> c. LENGTH OF STAY IN 1b <u>59 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>201 Old County Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md</u> f. COUNTY <u>A. A.</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> h. STREET ADDRESS <u>201 Old County Rd.</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>DAVID F. STEWART</u>		4. DATE OF DEATH <u>11 - 9 - 1966</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-7-07</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICER of CORP. WOOD PRODUCTS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND, A.A.C.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH S. STEWART</u>				14. MOTHER'S MAIDEN NAME <u>SUE FETTER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOC. SEC. NO. <u>2-15-09-057</u>				17. INFORMANT <u>HILDA STEWART</u>				Address <u>Above</u>			
18. CAUSE OF DEATH (Enter only one cause pertaining for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the larynx.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Jan. <u>1966</u> to <u>Nov 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 11, 1966</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Gene D. Trentin</u> 22b. PHYSICIAN'S NAME (Type) <u>GENE D TRENTIN</u> 22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>98 Cathedral St. Annapolis</u> 22e. DATE SIGNED <u>11/9/66</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>11-11-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>The Crematory</u> 23d. LOCATION (City, town or county) (State) <u>Annapolis A.C.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barranco</u> 24b. ADDRESS <u>Severna Park, Md</u> 25. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> 25c. DATE <u>NOV 14 1966</u>											



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15137

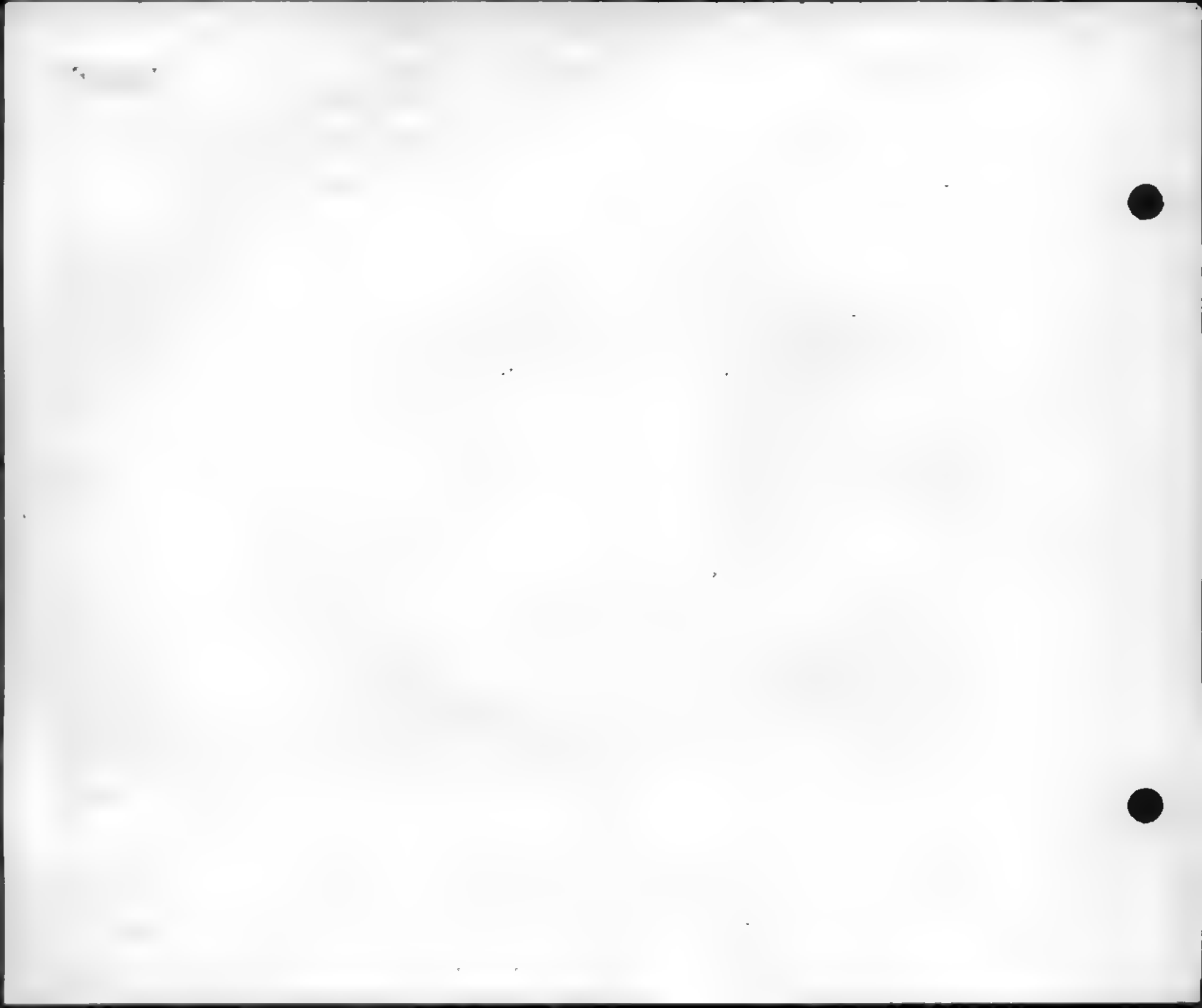
CERTIFICATE OF DEATH

15136

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN TB <u>1 hour</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel General Hospital</u>				d. STREET ADDRESS <u>Wards Chapel Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Herbert Stubler</u>				4. DATE OF DEATH Month Day Year <u>November 3 1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-1905</u>	9. AGE (in years last birthday) <u>61</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>communications oper.</u>		10b. K. NO. OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Jacob Stubler</u>				14. MOTHER'S MAIDEN NAME <u>Lina Schumann</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-03-6772</u>		17. INFORMANT Address <u>Catherine Wade 615 Pamela Rd. Glen Burnie</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 months</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-7-1948</u> , to <u>11-3-1966</u> , that (I) (we) last saw the deceased alive on <u>10-28-1966</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Len Ashman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-4-66</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>5907 GWYNN OAK AVE BALTIMORE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-7-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>Ellsworth</u>				ADDRESS <u>4600 Liberty Hgts. Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>f Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

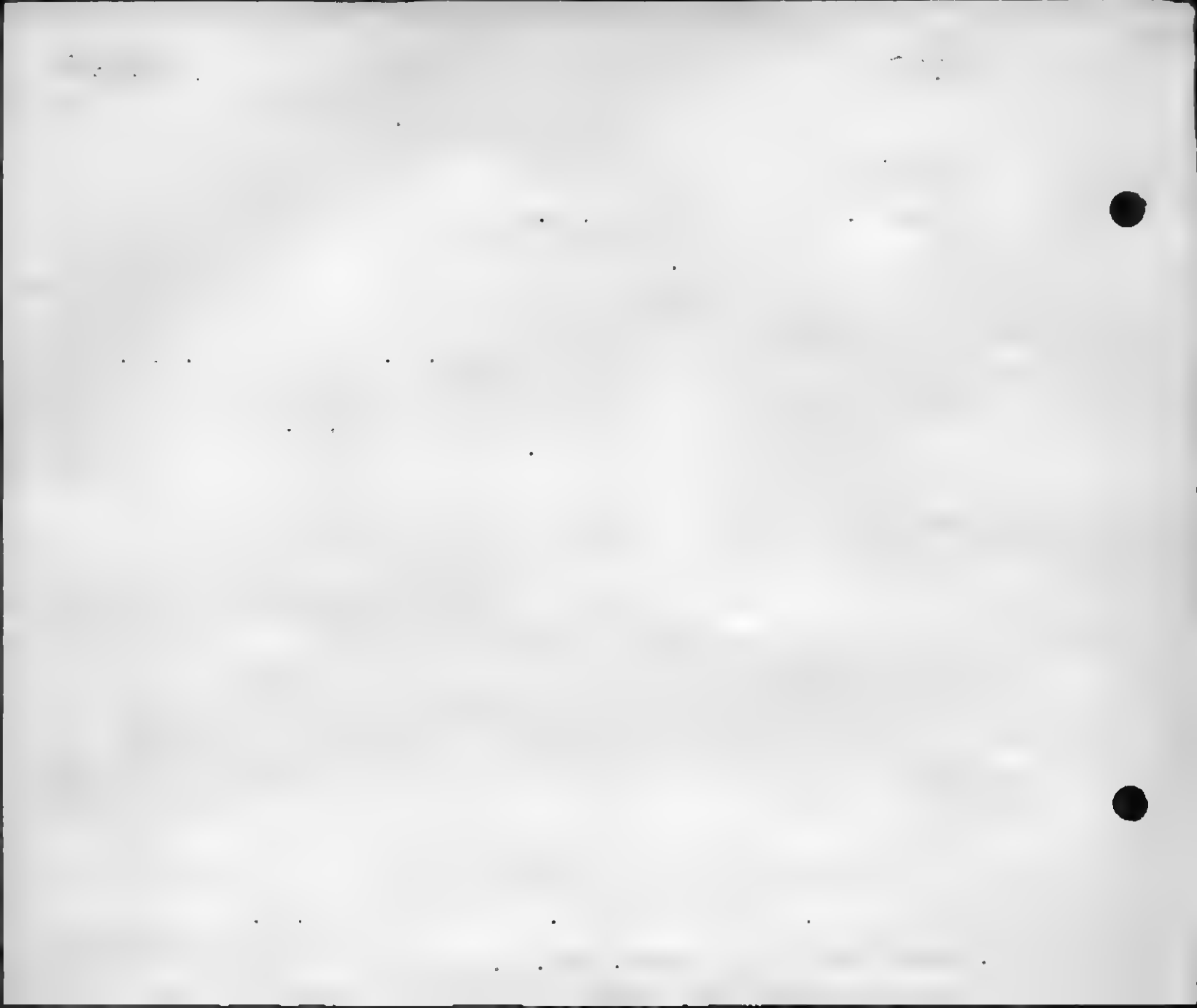
CERTIFICATE OF DEATH

15138

15137

1. PLACE OF DEATH a. COUNTY Ann Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Popular Ridge c. LENGTH OF STAY IN b. 12 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 310 Cedar Rd. Popular Ridge Pasadena, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Ann Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Popular Ridge d. STREET ADDRESS 310 Cedar Rd.	
3. NAME OF DECEASED (Type or print) Ethel A. Tegler		4. DATE OF DEATH Month NOV Day 30 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE, County & State, or foreign country Balto. Md.
13. FATHER'S NAME Westley Saunders		14. MOTHER'S MAIDEN NAME Catherine ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch of service) no		16. SOCIAL SECURITY NO. Mr. Harry A. Tegler Popular Ridge 310 Cedar Rd.	
17. INFORMANT Pasadena, Md. Address Mr. Harry A. Tegler Popular Ridge 310 Cedar Rd.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: TE CAUSE (a) ACUTE PULMONARY OEDEMA DUE TO 1100 (b) CHRONIC CARDIAC DECOMPENSATION DUE TO 1100 (c) SCLERA-DERMA PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MALNUTRITION AND CACHEXIA	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1958 to NOV 30, 1966 ; that (I) (we) last saw the deceased alive on NOV 16, 1966 , and that death occurred at 3 PM , from the causes and on the date stated above.			
22a. SIGNATURE Arthur Lankford Jr.		22b. DATE SIGNED 11-30-66	
22c. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR.		22d. ADDRESS MOUNTAIN RD PASADENA, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 3, 1966	23c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.	23d. LOCATION (City, town or county) (State) Balto. Md.
24. FUNERAL DIRECTOR'S SIGNATURE G. Truman Schwab		25a. REC'D BY REGISTRAR DEC 2 1966	
ADDRESS 3512 Frederick Ave. Balto. Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2BM 1/65

15139

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15138

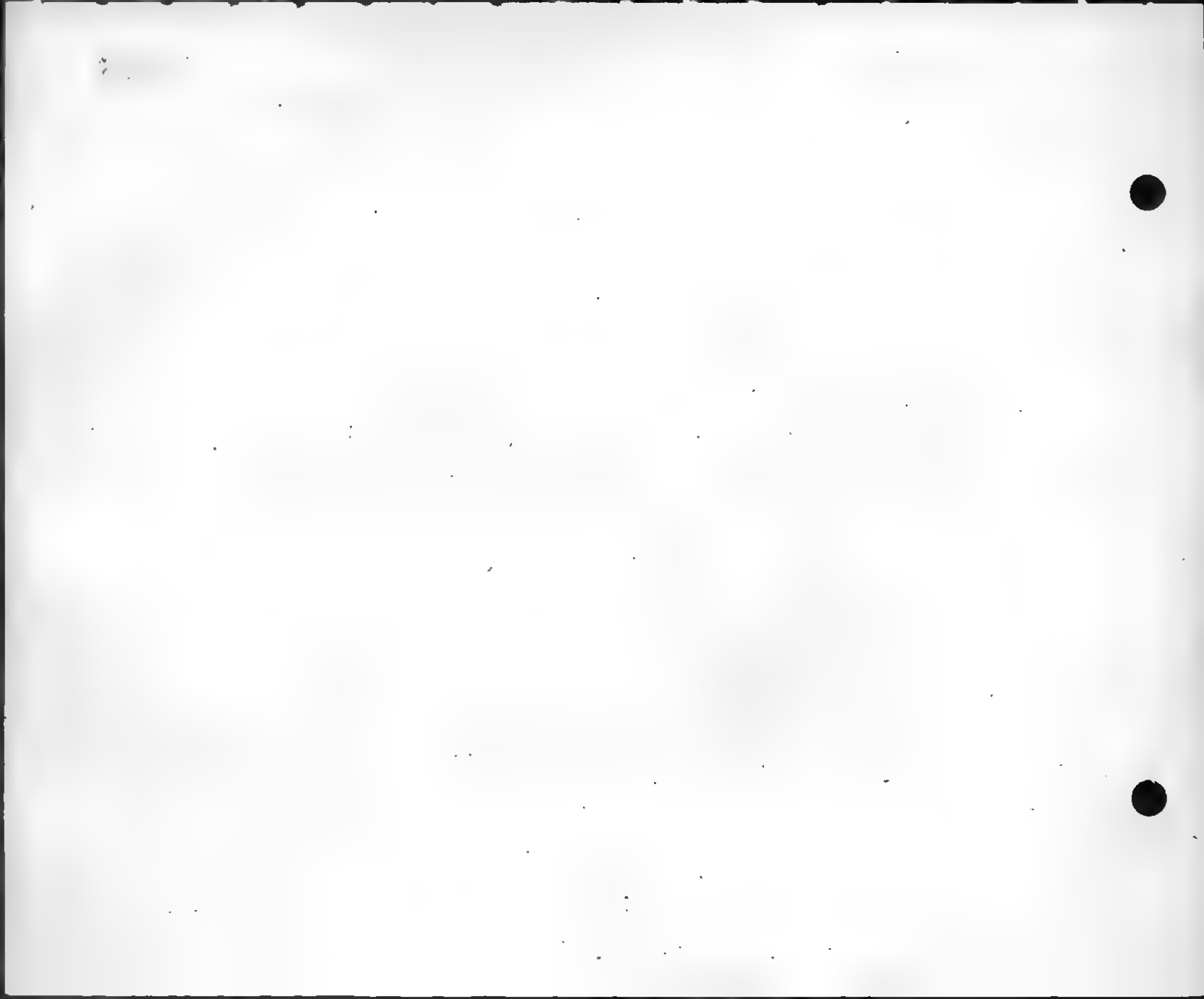
1. PLACE OF DEATH a. COUNTY <u>A.A.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>H & G</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold md</u>	
c. LENGTH OF STAY IN 1b <u>33 years</u>		d. STREET ADDRESS <u>Box 46 Rt 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Some Rt 1 Box 46</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emma May Thomas</u>		4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4, 1873</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jones Allen</u>		14. MOTHER'S MAIDEN NAME <u>Sandra League</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Margaret Ireland Higgins - alone</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>			
DUE TO (b) <u>A.C.V.D.</u>			
DUE TO (c) <u>Senility</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> , to <u>1966</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-23-66</u> , and that death occurred at <u>7 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert P. Holm</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Holm</u>		22d. ADDRESS <u>P.O. Box 73 Severna Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/30/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		23d. LOCATION (City, town or county) (State) <u>Severna Park md</u>	
24. FUNERAL DIRECTOR <u>Robert A. Baranick</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 29 1966</u>	

MEDICAL CERTIFICATION

TAXI
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

15139



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15140

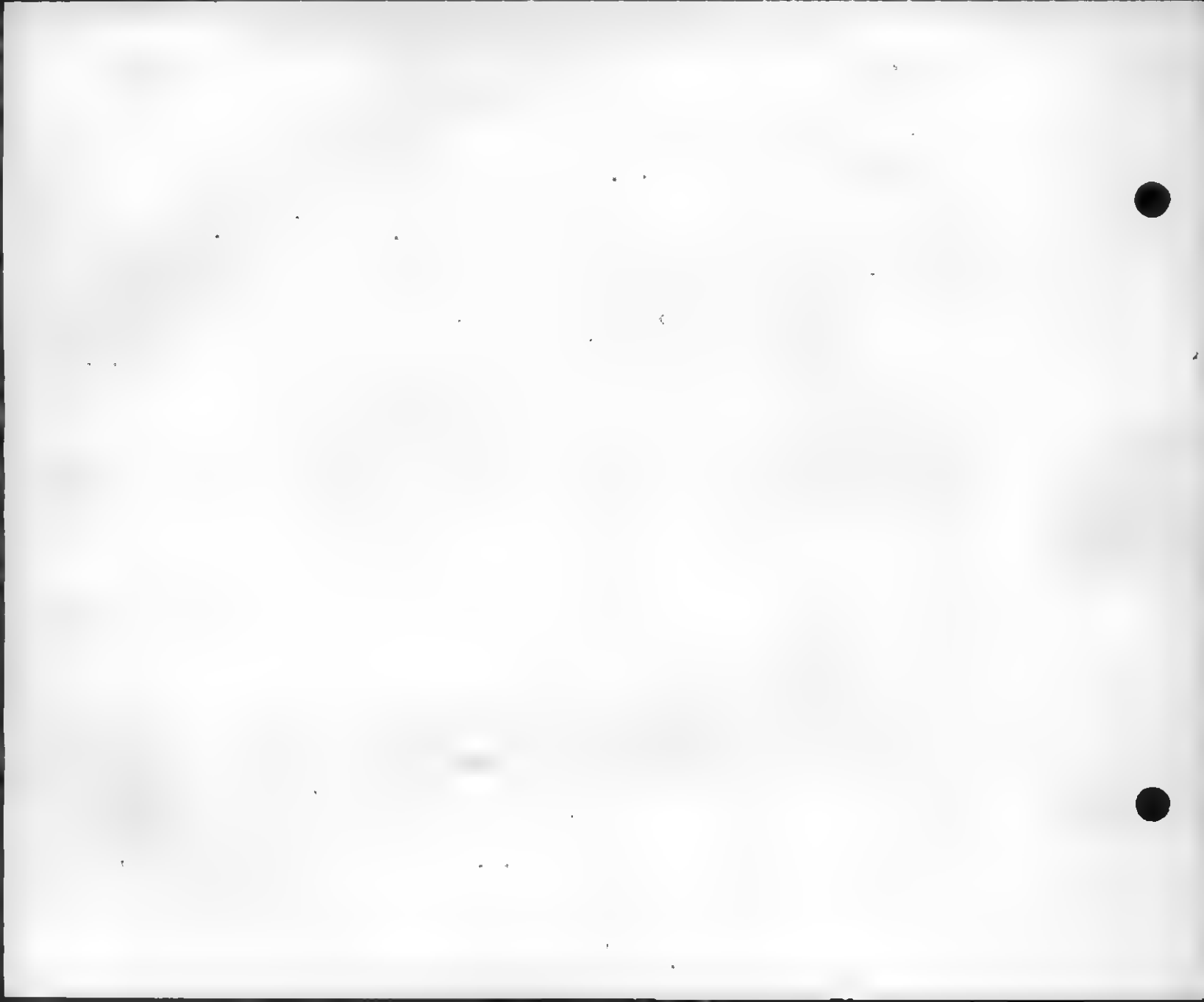
CERTIFICATE OF DEATH

16592

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) b STATE Maryland b COUNTY Baltimore City	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c LENGTH OF STAY in b 8 mos. 20 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 846 W. Baltimore St.	
3 NAME OF DECEASED (Type or print) 3-#31447 First Andy Middle Thompson Last Thompson		4 DATE OF DEATH Month 11 Day 24 Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May, 1893
9 AGE (In years birth-day) yrs. 73		IF UNDER 1 YEAR Months 11 Days 24 Hours 19 Min 66	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Norway		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Berl Thompson		14. MOTHER'S MAIDEN NAME Tina	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17 INFORMANT Hospital Records		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) -----			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema, Cerebral Atherosclerosis			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER) -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. --- 19		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 11/3/66 to 11/24 , 19 66 that (I) (we) last saw the deceased alive on 11/24 , 19 66 , and that death occurred at 1:38 M, from causes and on the date stated above.			
22a SIGNATURE Hildegard Heard Reissman M.D.		22b. DATE SIGNED 11/25/66	
22c PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D.		22d ADDRESS Crownsville State Hospital, Maryland	
23a B. J. RIAL, CREMATON, REMOVAL (Specify) Removal		23b DATE THEREOF 12/21/66	
23c. NAME OF CEMETERY OR CREMATORY UNIV. Md.		23d LOCATION (City or Town) (County) (State) BAIT Md.	
24. FUNERAL DIRECTOR William Reese II 108 W. Washington Street		25a. REC'D BY REGISTRAR DATE	
25b. REGISTRAR'S SIGNATURE -----			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

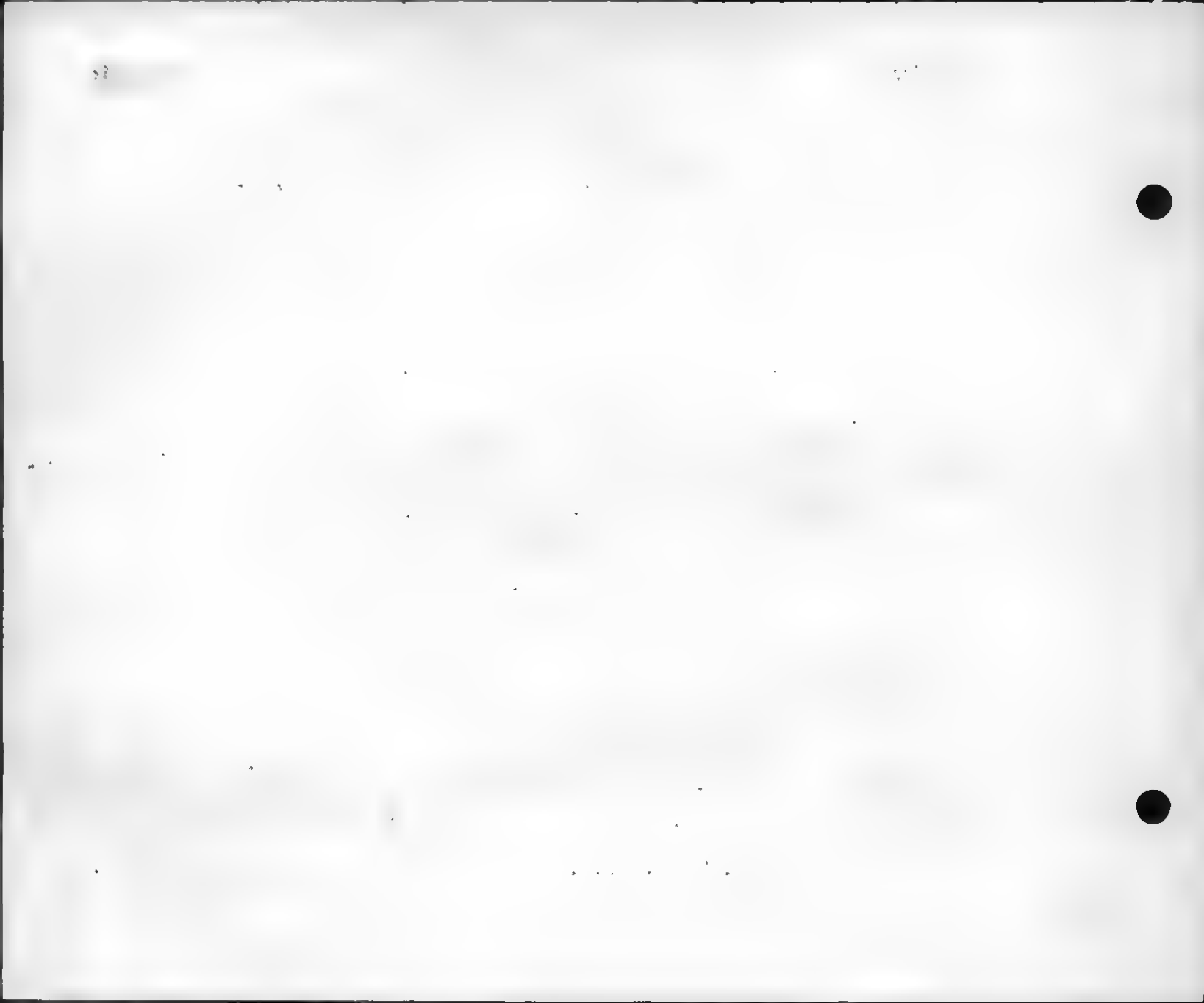
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15141

CERTIFICATE OF DEATH

15139

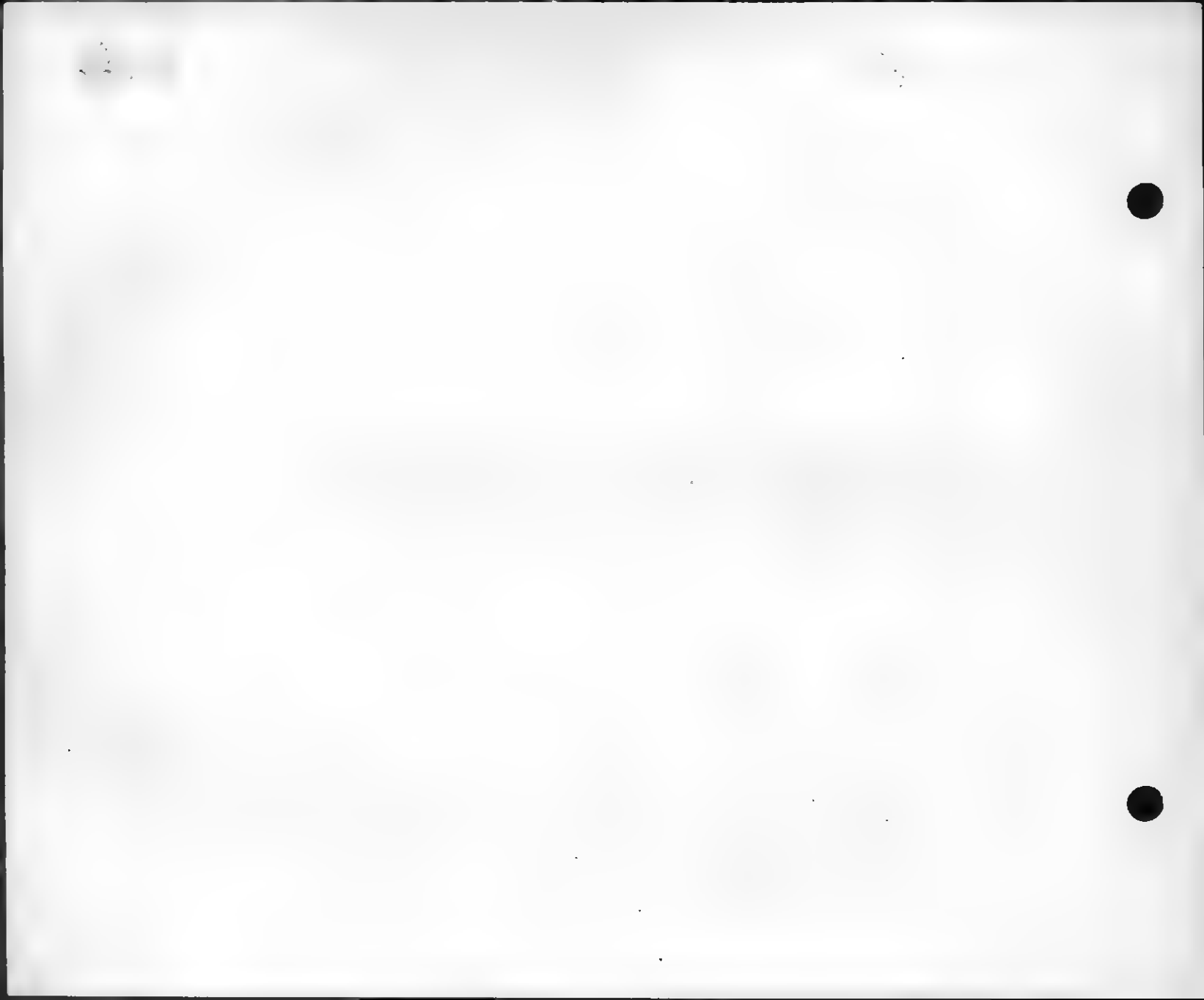
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Laurel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 31 yrs. 11 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Children's Center Hospital				d. STREET ADDRESS 754 Harvard Street, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle THORNTON Last THORNTON				4. DATE OF DEATH Month November Day 17 Year 19 66			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-17	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months 1 Days 17		IF UNDER 24 HRS Hours 19 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Thornton				14. MOTHER'S MAIDEN NAME Maggie Hamm			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Children's Center Hospital, Laurel, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Papillary adenocarcinoma, left lung DUE TO (b) Mental retardation DUE TO (c) Convulsive disorder						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 7, 1934 , to Nov. 17 , 19 66 that (I) (we) last saw the deceased alive on Nov. 17 19 66 , and that death occurred at 4:23 PM from causes and on the date stated above.							
22a. SIGNATURE <i>Margaret W. Mola</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov. 18, 1966	
22c. PHYSICIAN'S NAME (Type) MARGARET W. MOLA, M.D.				22d. ADDRESS Children's Center, Laurel, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/66		23c. NAME OF CEMETERY OR CREMATORY Children's Center		23d. LOCATION (City or town) (County) (State) Laurel A. A. Md.	
24. FUNERAL DIRECTOR <i>De Witt Donaldson</i>				ADDRESS <i>Laurel, Md.</i>		25a. REC'D BY REGISTRAR DATE NOV 29 1966	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15143

CERTIFICATE OF DEATH

15141

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Edgewater	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt. 3, Box 293	
3. NAME OF DECEASED (Type or print) First Charles Middle A. Last TUCKERMAN		4. DATE OF DEATH November 9 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 4, 1887
9. AGE (n years last birthday) 79 yrs		IF UNDER 1 YEAR Months 9 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Clerk		10b. KIND OF BUSINESS OR INDUSTRY Hardware	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alexander Tuckerman		14. MOTHER'S MAIDEN NAME Minerva Yunkes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Lyda L. Tuckerman	
17. INFORMANT Lyda L. Tuckerman		Address # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized metastatic carcinoma DUE TO carcinoma prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1965 to 11-9 , 19 66 that (I) (we) last saw the deceased alive on 11-8 , 19 66 , and that death occurred at 3:00 A.M. M, from causes and on the date stated above.			
22a. SIGNATURE Emily H. Wilson		22b. DATE SIGNED 11/9/66	
22c. PHYSICIAN'S NAME (Type) Emily H. Wilson, M.D.		22d. ADDRESS LOTHIAN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF 11-11-1966	23c. NAME OF CEMETERY OR CREMATORY Glen Haven	23d. LOCATION (City or Town) (County) (State) Glen Burnie Md.
24. FUNERAL DIRECTOR John M. Laylow + Sons Annapolis, Md.		25a. REC'D BY REGISTRAR NOV 15 1966	
25b. REGISTRAR'S SIGNATURE John M. Laylow			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11-11

11-11



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. General Hosp.</u>		d. STREET ADDRESS <u>99 Edot St.</u>	
3. NAME OF DECEASED (Type or print) <u>James A. Vaughan, Sr.</u>		4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1913</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. FUNDING PERIOD FUNDER 1 Year <u>9</u> FUNDER 24 HRS. <u>11</u> Months <u>9</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Acad.</u>	
11. BIRTHPLACE (State or foreign country) <u>Henderson, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Vaughan</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Kearney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>312-18-3996</u>	
17. INFORMANT <u>Henretta Vaughan</u>		Address <u>54025 St. 7th Ave. N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medicine</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1544</u> DUE TO (c) <u>Choke</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Choke</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>29</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <u>11-9-66</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>11/14/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	
23d. LOCATION (City, town or county) (State) <u>Annapolis, Md.</u>		24. FUNERAL DIRECTOR <u>William Reese, II - Annap. Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>NOV 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15145

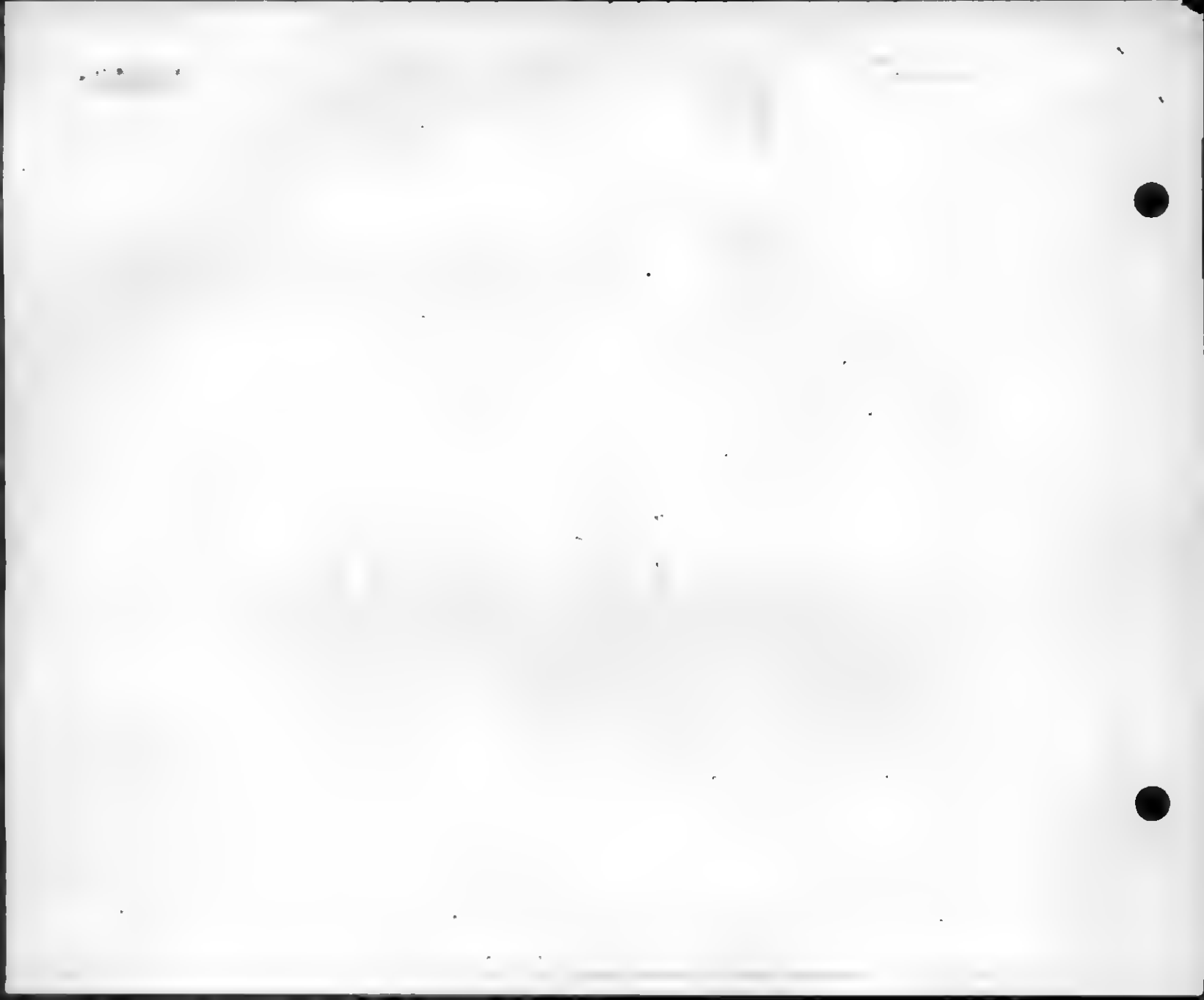
CERTIFICATE OF DEATH

15143

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u> </u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>312 Simms Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>L.</u> Last <u>Walker</u>		4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-7-28</u>
9. AGE (In years lost birthday) <u>38</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>David F. Walker</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Mae Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>Leroy Walker - Hannover, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Intracerebral Hemorrhage</u> (b) <u>Left Hemisphere</u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>66</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> , 19 <u>66</u> , to <u>11/15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> , 19 <u>66</u> , and that death occurred at <u>5:40</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. B. Ramirez</u>		22b. DATE SIGNED <u>11/15/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. B. Ramirez MD</u>		22d. ADDRESS <u>3427 ANNAPOLIS RD - 2nd fl</u> <u>Room 1672 North Baltimore Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/18/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Fort Meyers, Va.</u>
24. FUNERAL DIRECTOR <u>Robert P. Ware</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. ADDRESS <u>Singleton Funeral Home/Glen Burnie, Md.</u>		25. REC'D BY REGISTRAR <u>NOV 21 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

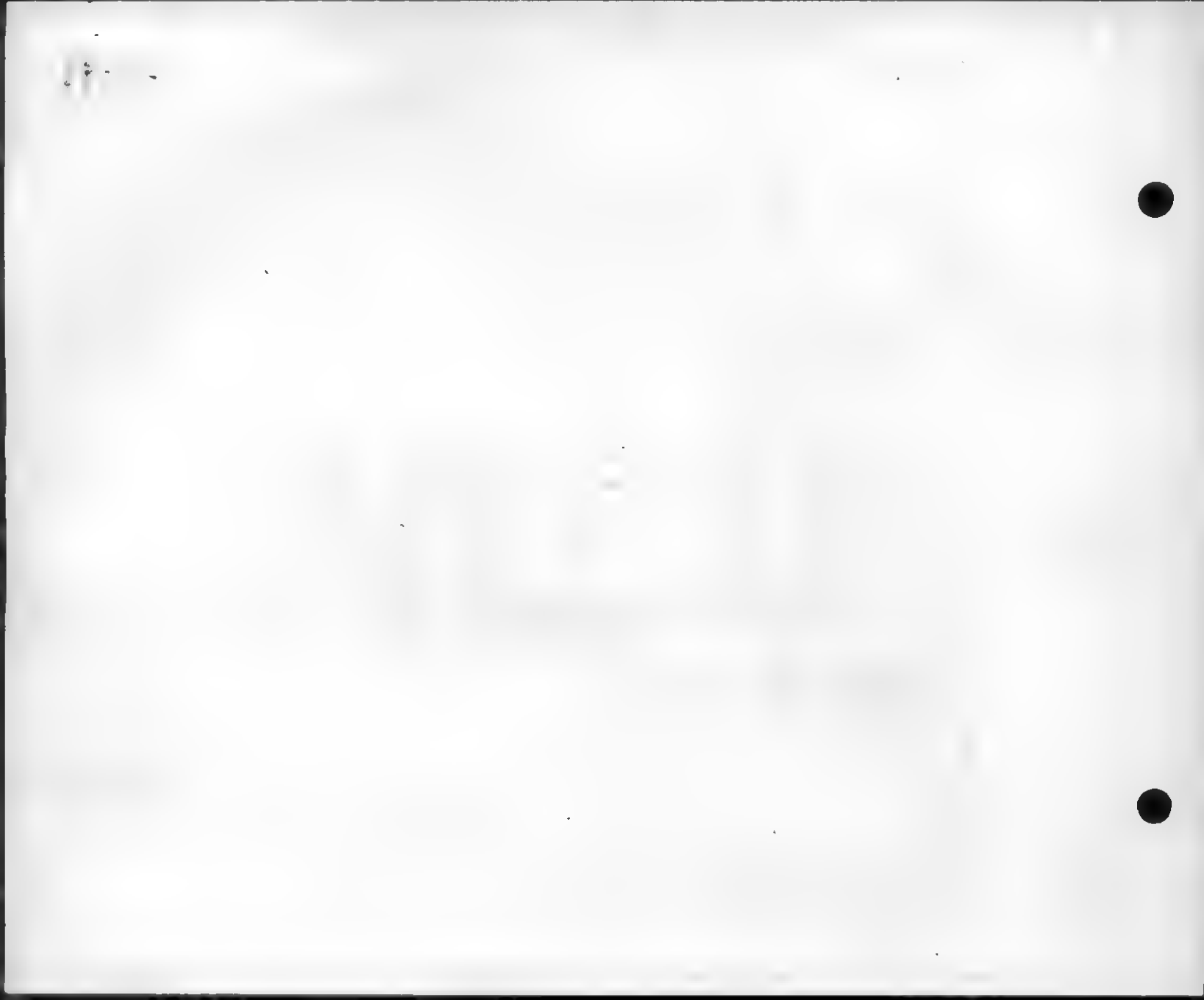
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15146

CERTIFICATE OF DEATH

15144

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>3 Weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>Holy Cross Rd + Main Ave. (Park)</u>	
3 NAME OF DECEASED (Type or print) First <u>JANE</u> Middle <u>D.</u> Last <u>Waiker.</u>		4 DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>January 15, 1915</u>
9 AGE (In years lost birthday) <u>51</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Alto-Bd. of Ed.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Millersville Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Knott</u>		14. MOTHER'S MAIDEN NAME <u>Jamex Martin</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>214-30-3647</u>	
17 INFORMANT <u>Mrs. Betty L. Chisolm (daughter)</u>		Address <u>3807 Pascal Ave. Balto. #25, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolism</u> <u>4331</u> DUE TO (b) <u>Pulmonary infection with Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Paroxysmal atrial tachycardia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour <u> </u> m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>10/13</u> , 19 <u>66</u> to <u>11/2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/2</u> , 19 <u>66</u> , and that death occurred at <u>12:15</u> P.M., from causes and on the date stated above.			
22a SIGNATURE <u>Bullens A. Jensen</u> M.D.		22b. DATE SIGNED <u>11/2/66</u>	
22c PHYSICIAN'S NAME (Type) <u>G. Linsao</u>		22d. ADDRESS <u>North Arundel Hosp., Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Nov. 7, 1966</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Sedar Hill Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Brooklyn, RFD, Maryland</u>	
24. FUNERAL DIRECTOR <u>R. Singleton</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>NOV 7 1966</u>		DATE <u>NOV 7 1966</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

15147

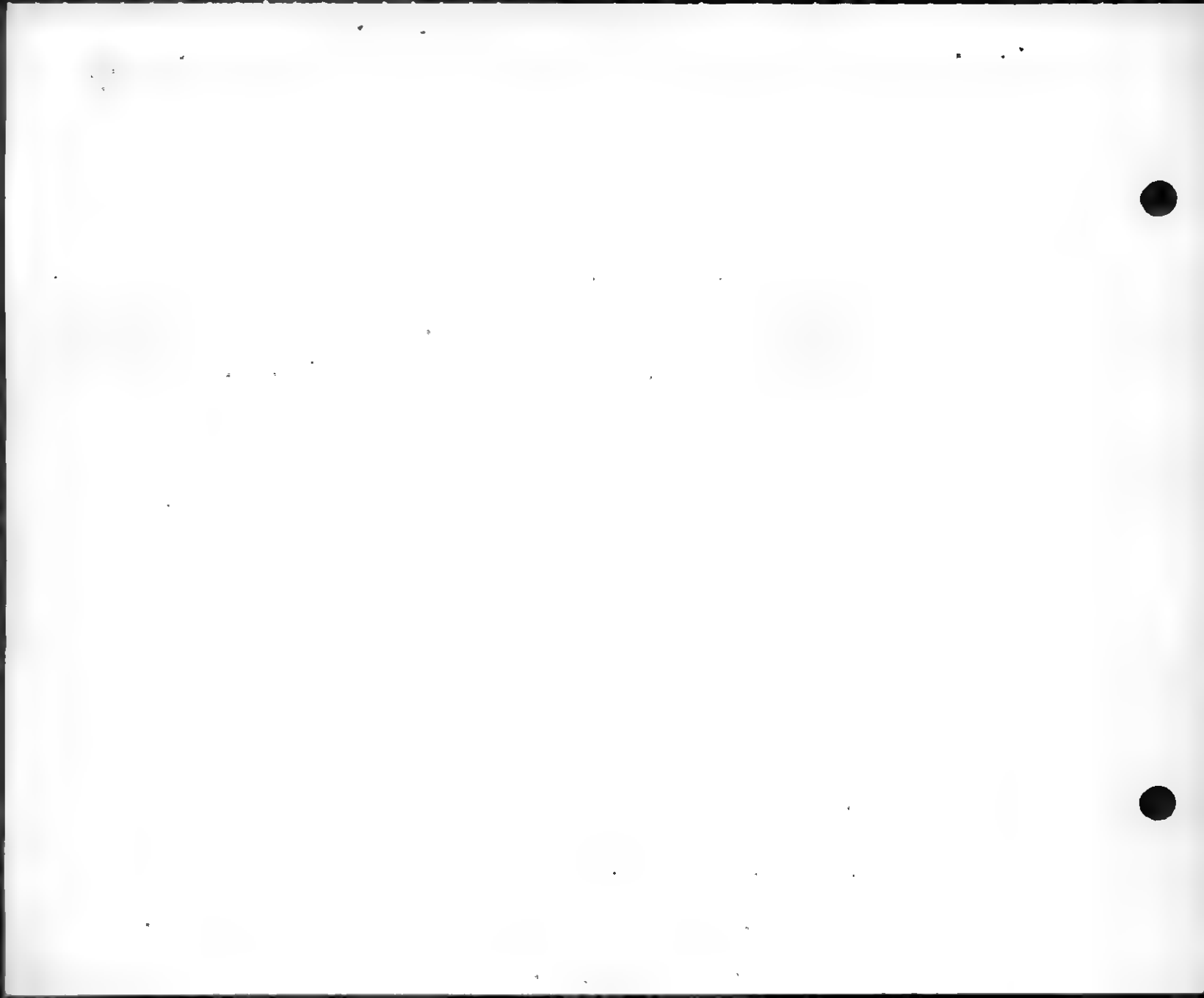
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15145

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY ANNE ARUNDEL b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE c LENGTH OF STAY IN 1b Severn d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL GENERAL HOSPITAL		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Anne Arundel c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn d STREET ADDRESS Camp Meade Road e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last WOODSIDE E. WARFIELD		4 DATE OF DEATH Month Day Year 11 28 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 19 Jan. 1902
9 AGE (In years last birthday) 64 yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY U. S. Gov't	
11 BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Benjamin Warfield		14 MOTHER'S MAIDEN NAME Ida Durm	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Mrs Dorothy T. Warfield, same as 2		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic and hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) disease (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Noturo causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 11-29-66	
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2 Dec. 1966	23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery	23d. LOCATION (City or Town) (County) (State) Linthicum, Md.
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DEC 1 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

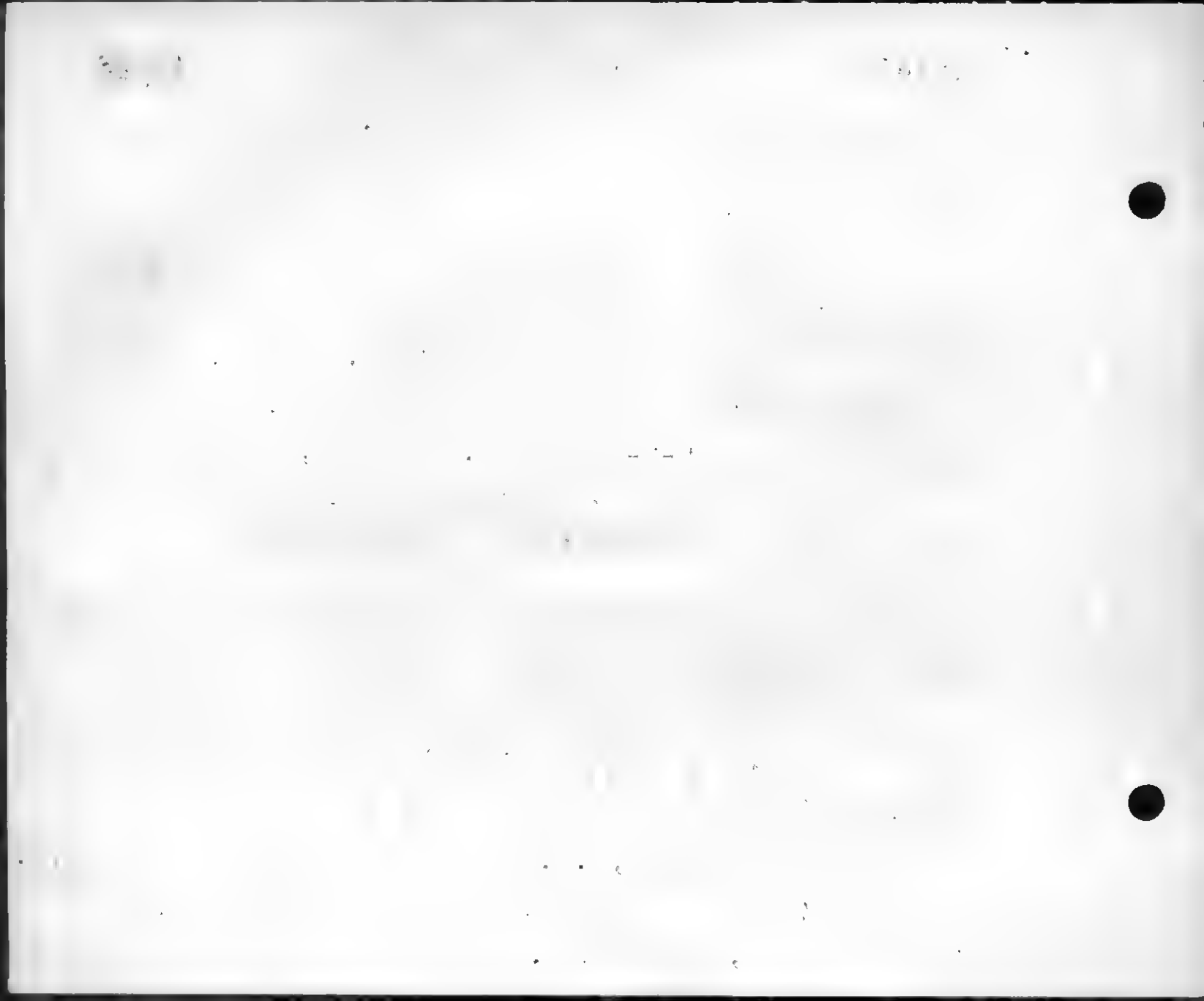


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15148
CERTIFICATE OF DEATH
15148

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>106 Phelps Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>May</u> Last <u>Watts</u>		4. DATE OF DEATH Month <u>10</u> Day <u>November</u> Year <u>1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 May 1881</u>	
9. AGE (in years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Marietta, Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>August Weaver</u>	
14. MOTHER'S MAIDEN NAME <u>Carrie Zink</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>212-16-3720 D</u>		17. INFORMANT <u>Mrs. Helen Namuth, same as 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> T x U I DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>May 8, 1963</u> to <u>Nov. 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov. 8, 1966</u> , and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above.	
22a. SIGNATURE <u>Edmond I. Moushabek</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Edmond I. Moushabek, M. D.</u>		22d. ADDRESS <u>510 Marley Station Road, Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>14 Nov. 66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15149

CERTIFICATE OF DEATH

15147

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Epping Forest</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Epping Forest</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Epping Way</u>		d. STREET ADDRESS <u>Epping Way</u>	
3. NAME OF DECEASED (Type or print) <u>ROBERT G. WATTS Sr.</u>		DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-1896</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CHAMBERSBURG Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES B. WATTS</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE GELVIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WELL M. WATTS #2</u>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>INANITION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>18 NOV</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11 NOV 1966</u> , and that death occurred at <u>2 A</u> M, from causes on and on the date stated above		
22a. SIGNATURE <u>Edward S. Beale</u>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/18/66</u>
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>11-21-66</u>	<u>NORLAND</u>	<u>CHAMBERSBURG Pa.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons</u>	ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 21 1966</u>
			25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15150

CERTIFICATE OF DEATH

15148

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSONVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KNOLLWOOD NURSING HOME</u>		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>CHARLES ST. CLAIR WAYSON SR.</u>		4. DATE OF DEATH <u>Nov 5 1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 30 1878</u>
9 AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11 BIRTHPLACE (County & State, or foreign country) <u>MCKINDREE MD</u>	
12 C. ITZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LOUIS PRESTON WAYSON</u>	
14. MOTHER'S MAIDEN NAME <u>ELIZABETH SIMMONS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. W. N. BRASHEARS</u> Address <u>16 EASTERN AVE ANNAPOLIS MD.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a SIGNATURE <u>B.M. Smith</u>		22b. DATE SIGNED <u>7 Nov, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>B.M. SMITH</u>		22d. ADDRESS <u>Hahn Bldg. SEVERNA PARK, MD.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-8-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ALL HALLOWS CHAPEL</u>	23d. LOCATION (City or Town) (County) (State) <u>DAVIDSONVILLE MD.</u>
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR, SON ANNAPOLIS MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>NOV 10 1966</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

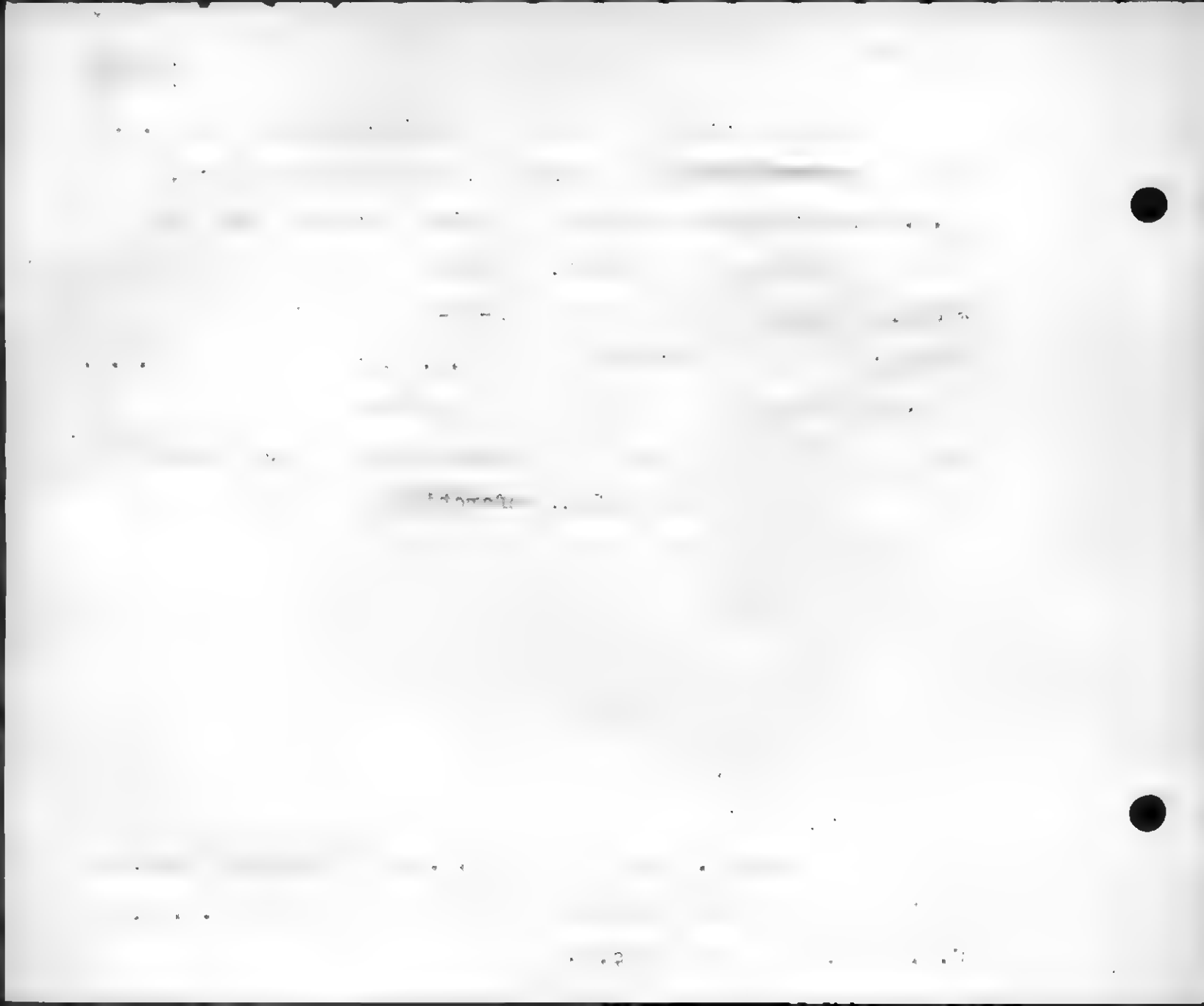


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.Co					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Severna Park						c. LENGTH OF STAY IN 1b 36 years					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A Anne Arundel Gen Hosp						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Severna Park, Md					
f. STREET ADDRESS Whites Road Box 340A Rtl						g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Bernice Delores White						4. DATE OF DEATH Month Nov Day 10 Year 19 66					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-20-1902		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) A.A.Co, Md				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Pulley						14. MOTHER'S MAIDEN NAME Cynthia ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) *****				16. SOCIAL SECURITY NO. None		17. INFORMANT James Albert White				Address Severna, Park Rtl Box 340A	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) M C V D DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1956 , 19____, to____, 19____, that (I) (we) last saw the deceased alive on May 19 66 , and that death occurred at 11 30 PM , from the causes and on the date stated above.											
22a. SIGNATURE <i>Robert R. Hahn</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-10-66	
22c. PHYSICIAN'S NAME (Type) Robert R. Hahn						22d. ADDRESS P.O. Box 73 Severna Park, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/13/66		23c. NAME OF CEMETERY OR CREMATORY Mt Calvary			23d. LOCATION (City, town or county) (State) Arnold A.A.Co Md			
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Md						25a. REC'D BY REGISTRAR DATE NOV 16 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

15152

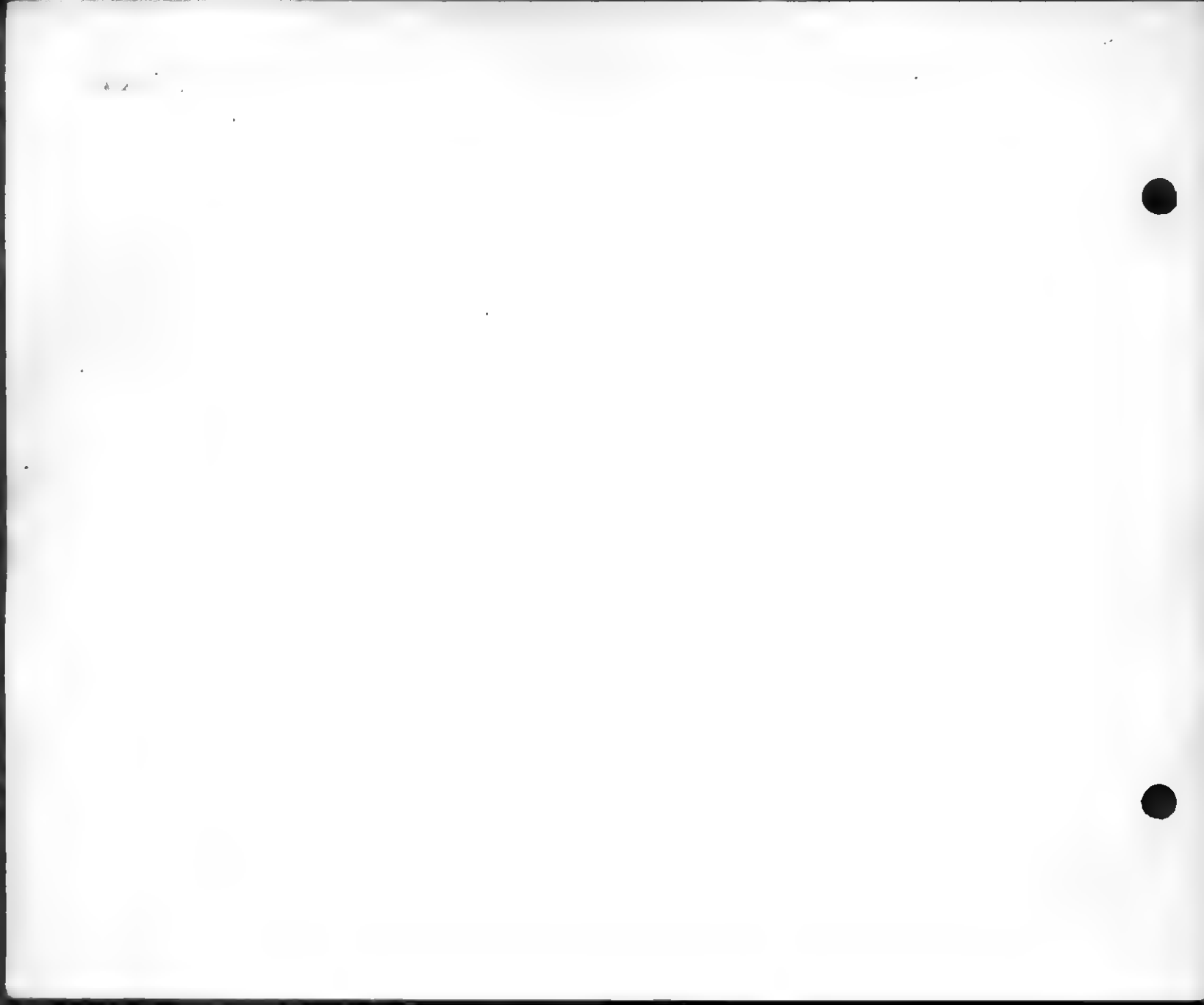
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15150

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY —	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Glen Burnie		c LENGTH OF STAY IN 1b 31	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 1654 Delano Court	
3 NAME OF DECEASED (Type or print) First Middle Last CATHRYN O. WILLIAMS		4 DATE OF DEATH Month Day Year November 4 19 66	
5 SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 20, 1950
9 AGE (In years last birthday) 16 yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto., Maryland		2 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Oscar Williams		14. MOTHER'S MAIDEN NAME Sarah Seaberry	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Mr. Oscar Williams		Address 3200 Burleigh Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spinal Cord Compression 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of Cervical Vertebrae. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in auto-auto collision.	
20c. TIME OF INJURY Month, Day, Year 2:15 p.m. 11/4 9 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Beltway
20f. (City or town) Anne Arundel		(County) (State) Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty		22. DATE SIGNED 11/4/66	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 11-8-66	
23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION (City or Town) (County) (State) Arbutus Md.	
24. FUNERAL DIRECTOR Morton & Dyett F.H.		ADDRESS 1701 Laurens Street	
25a. REC'D BY REGISTRAR NOV 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15153

CERTIFICATE OF DEATH

15151

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Watergate- Annapolis		c. LENGTH OF STAY IN 1b 02.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1507 Gordon Cove Drive		d. STREET ADDRESS 1507 Gordon Cove Drive	
3. NAME OF DECEASED (Type or print) JOHN WILLIAMS, Sr.		4. DATE OF DEATH Month Nov. Day 25 Year 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 28, 1884
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker - ret.		10b. KIND OF BUSINESS OR INDUSTRY self-employed	
11. BIRTHPLACE (County & State, or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? Denmark	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. none	
17. INFORMANT son-John Williams, Jr.		18. ADDRESS 38 Monroe Ct., Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate DUE TO (b) 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/17, 1963 , to 11/25, 1966 , that (I) (we) last saw the deceased alive on 6/23, 1966 , and that death occurred on 10A-M , from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman		22b. DATE SIGNED 11/26/66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St. Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 28, 1966	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.
24. FUNERAL DIRECTOR Beverley E. Hopping HOPPING FUNERAL HOME - Annapolis, Md.		25. REC'D BY REGISTRAR NOV 30 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

15151

15151



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15154

CERTIFICATE OF DEATH

15152

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Laurel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 7 yrs. 11 mos	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.		473	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Children's Center Hospital		d. STREET ADDRESS Crippled Children's Hospital	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Richard Patrick Young		4. DATE OF DEATH Month Day Year Nov. 25 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-56
9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Edythe Barbara Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Children's Center Hospital, Laurel, Md.	
17. INFORMANT Children's Center Hospital, Laurel, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration (vomitus) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mental retardation - severe DUE TO (c) Athetoid quadriplegia		INTERVAL BETWEEN ONSET AND DEATH 11/25/66	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1959 , to Nov. 25, 1966 , that (I) (we) last saw the deceased alive on Nov. 25, 1966 , and that death occurred at 7:25 P.M. from causes on and on the date stated above.			
22a. SIGNATURE James E. Boyland		22b. DATE SIGNED Nov. 28, 1966	
22c. PHYSICIAN'S NAME (Type) JAMES E. BOYLAND, M. D.		22d. ADDRESS Children's Center, Laurel, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Nov. 30, 1966		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Children's Center		23d. LOCATION (City or Town) (County) (State) Laurel A. A. Md.	
24. FUNERAL DIRECTOR Dr. Witt Donaldson Laurel, Md		25a. REC'D BY REGISTRAR DATE DEC 6 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

56164

45121